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PROVIDER REFERENCE MODULE

Division of Mental Health
and Addiction

Adult Mental Health Habilitation Services

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Section 1: Introduction

This module is a resource specifically for Adult Mental Health Habilitation (AMHH) service providers approved by the Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) and enrolled as an active Indiana Health Coverage Programs (IHCP) provider.

Section 6086 of the Deficit Reduction Act of 2005 (DRA), Public Law Number 109-171, expanded access to home and community-based services (HCBS) for the elderly and disabled by adding a new section 1915(i) to the *Social Security Act* (“the Act”). Under section 1915(i), states have the option to amend the state plans to provide HCBS without regard to state-wideness or certain other Medicaid requirements. AMHH services are approved by the Centers for Medicare & Medicaid Services (CMS) as 1915(i) HCBS programs and may be provided for 5 years following CMS approval of the State Plan Amendment (SPA) to provide AMHH services. The CMS initially approved the AMHH HCBS benefit September 25, 2013, with an effective date of October 1, 2013. The DMHA submitted the AMHH renewal application to the CMS with an effective date of October 1, 2018.

Indiana adopted the AMHH program to provide home and community-based opportunities for the care of adults with serious mental illness (SMI), with or without co-occurring substance use disorders, who may benefit most from a habilitative approach to care versus a rehabilitative approach.

Habilitation versus Rehabilitation

The distinction of whether a service is rehabilitative versus habilitative is often more rooted in an individual’s level of functioning and needs than in the actual services provided. Federal law describes Medicaid rehabilitation services as any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a member to his or her best possible functional level. Habilitation services, by comparison, are defined as activities that are designed to assist individuals in acquiring, retaining, and improving the following skills necessary to reside successfully in a community setting:

- Self-help
- Socialization
- Adaptive skills

AMHH services are indicated as a service alternative for individuals who have achieved maximum benefit from Medicaid Rehabilitation Option (MRO) services (see the [Medicaid Rehabilitation Option Services](#) provider module) and whose needs can be better met through habilitation. Possible candidates for AMHH services are individuals who have reached their capacity for improving their level of functioning, but need to retain their current functional level to remain in the community. Habilitation services benefit the individuals by providing the skills and supports needed to safely remain in a community-based setting and reduce the risk for institutionalization. Eligibility for AMHH services is determined based on a Medicaid-enrolled individual’s meeting specific target and needs-based criteria outlined in this module.

This AMHH provider module gives links to DMHA policies and procedures for the AMHH program, lists DMHA-certified community mental health centers (CMHCs), and documents State and federal expectations for AMHH service providers. It also includes guidance regarding enrollment, service delivery, clinical documentation, billing, and determining AMHH member eligibility. This module is intended to be used in conjunction with the following resources:

- [1915\(i\) AMHH State Plan Amendment TN 18-007](#)
- [1915\(b\)\(4\) Selective Contract for AMHH/BPHC Waiver](#) (IN.02.001)

- [405 IAC 5-21.6](#) (Indiana Administrative Code for AMHH services)
- Indiana Health Coverage Programs (IHCP) [Medical Policy Manual](#) and expectations issued by the FSSA
- DMHA updates or policy revisions to the AMHH program or requirements for AMHH providers, available on the [Adult Mental Health Habilitation Services](#) page at in.gov/fssa/dmha
- Other IHCP provider reference modules, including [Home and Community-Based Billing Guidelines](#) and [Claim Submission and Processing](#)
- Other communications issued by the CMS or the FSSA's DMHA or Office of Medicaid Policy and Planning (OMPP), including those posted on the [News, Bulletins, and Banner Pages](#) page at in.gov/medicaid/providers

Approved [AMHH service providers](#) are required to review, understand, and follow AMHH program policies and procedures, as well as any subsequent updates or revisions issued by the CMS, DMHA, or OMPP. Failure to comply with State and federal regulations associated with the AMHH program and the expectations outlined in this provider module will lead to formal corrective actions, State and federal sanctions, or termination as an AMHH service provider.

Section 2: Adult Mental Health Habilitation Program Overview

Adult Mental Health Habilitation (AMHH) services are medical or remedial services recommended by a physician or psychologist endorsed as a health service provider in psychology (HSPP), within the scope of his or her practice, for the habilitation of a mental health disability and the restoration or maintenance of an individual's best possible functional level. AMHH services are also clinical and supportive behavioral health services provided for individuals, families, or groups of adults who are living in the community and who need aid on a routine basis for mental illness or co-occurring mental illness and addiction disorders.

AMHH services are designed to assist in the habilitation of the individual's optimum functional ability in daily living activities. This goal is accomplished by:

- Assessing the individual's needs and strengths
- Developing an Individualized Integrated Care Plan (IICP) that outlines objectives of care, including how AMHH services will assist in delivering appropriate home and community-based habilitation services to the individual
- Assisting the individual in reaching his or her habilitative goals

AMHH services are intended to benefit the following individuals:

- Adults living in home and community-based settings who need routine help with managing serious mental illness (SMI) or co-occurring mental illness and addiction disorders
- Adults who have reached the maximum benefit from a rehabilitative treatment approach and would be better served with access to a habilitative approach to services to help them maintain and enhance treatment gains
- Adults who have a high need for services and are considered at risk of institutionalization without access to intensive community-based services

Indiana has chosen to make AMHH services available for the following reasons:

- AMHH services will assist adults with SMI, with or without a co-occurring substance use disorder, in reaching or maintaining the highest level of independence and functioning possible through the reinforcement, management, adaptation, and retention of skills necessary to live successfully in the community.
- Individuals with SMI who are limited in the ability for self-care and independence are empowered to remain integrated in the community with an appropriate level of supervision, services, and supports.
- Services will improve "quality of life" for individuals with SMI living in the community and decrease the need for institutional care.
- AMHH services fill a gap between Medicaid Rehabilitation Option (MRO) and Medicaid outpatient mental health services (as defined under *Indiana Administrative Code 405 IAC 5-20-8*).

Types of AMHH Services

The following AMHH services are available, according to the coverage criteria, limitations, and eligibility requirements specified in this module, the AMHH State Plan Amendment (SPA), and 405 IAC 5-21.6:

- Adult Day Service
- Home and Community-Based Habilitation and Support
- Respite Care
- Therapy and Behavioral Support Services
- Addiction Counseling
- Peer Support Services
- Supported Community Engagement Services
- Care Coordination
- Medication Training and Support

Home and Community-Based Setting Requirements

As mandated in the Centers for Medicare & Medicaid Services (CMS)-approved 1915(i) AMHH SPA and 405 IAC 5-21.6, AMHH services will be furnished to individuals in their homes or other community-based settings, not in institutions. Additional information is available at the Family and Social Services Administration (FSSA) [Home and Community-Based Services Final Rule Statewide Transition Plan](#) page at in.gov/fssa/da.

See [Section 4: AMHH Member Home and Community-Based Settings Requirements](#) in this module for additional information.

As of March 17, 2019, all DMHA provider owned, controlled, or operated (POCO) and non-POCO settings are compliant with the setting requirements of the HCBS final rule outlined in [Indiana's Statewide Transition Plan](#).

Length of Authorization Period

A Medicaid-eligible AMHH member is authorized to receive AMHH services on an approved IICP for 1 year (360 days) from the start date of AMHH eligibility, or as determined by the FSSA Division of Mental Health and Addiction (DMHA) State Evaluation Team (SET). Services may be provided according to the DMHA-approved IICP as long as the member continues to meet AMHH eligibility criteria. After an applicant is determined eligible for the AMHH program, the SET approves AMHH services based on review of documentation and the IICP.

AMHH Service Coverage Requirements

For a service to be reimbursable under the AMHH program, it must meet the following minimum criteria:

- Be provided to a member who has an active Medicaid aid category on the date of service
- Be provided to an individual determined by the DMHA SET as eligible for AMHH services
- Be a service proposed on the member's IICP and approved by the SET
- Be a covered AMHH service, as described in this provider module

- Be provided in a manner that is within the scope and limitations of the AMHH service, including provider qualifications
- Be supported in clinical documentation as a service that:
 - Continues to promote stability for the AMHH member
 - Enables the member to move toward obtaining the habilitative goals identified in the individual's IICP

Noncovered Services

While each AMHH service may have its own exclusions unique to that service, the following services are considered noncovered and are not eligible for reimbursement under the AMHH program:

- A service provided to the member at the same time as another service that is the same in nature and scope, regardless of funding source, including federal, State, local, and private entities (for example, a Behavioral and Primary Healthcare Coordination (BPHC) or 1915(c) waiver service)

Note: For any service provided simultaneously with another service, only one of the services provided is billable.

- A service provided as a diversion, leisure, or recreational activity, unless it is an identified component of an approved Respite Care service
- A service that is provided in a manner that is not within the scope and limitations of the AMHH service
- A service not on the member's IICP
- A service that is on the member's IICP but is not documented as a covered or approved service by the SET
- A service provided that exceeds the limits within the service definition, including service quantity or limit, duration, or frequency
- Any service provided on the same day that the member is receiving inpatient or partial hospitalization through Medicaid
- Time spent on the initial face-to-face assessment, referral form, and IICP may not be billed under AMHH

Crisis Intervention Services

As noted in 405 IAC 5-21.5-8, services reimbursable as crisis intervention services are short-term emergency behavioral health services, available 24 hours per day, 7 days per week.

These services include crisis assessment, planning, and counseling specific to the crisis, intervention at the site of the crisis when clinically appropriate, and prehospital assessment. The goal of crisis services is to resolve the crisis and transition the client to routine care through stabilization of the acute crisis and linkage to necessary services. This service may be provided in an emergency room, crisis clinic setting, or in the community.

Crisis intervention is a covered service for any Medicaid member; however, it is not a service that is defined in the AMHH SPA. If an AMHH member needs crisis intervention services, he or she may access these services.

Section 3: AMHH Agency Staff Requirements

Adult Mental Health Habilitation (AMHH) services may be delivered only by service provider agencies meeting specific State-defined criteria. Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) certifies agencies to provide AMHH services to eligible members. DMHA-approved providers must also be enrolled as authorized Indiana Health Coverage Programs (IHCP) providers with the AMHH specialty.

AMHH-approved IHCP-enrolled providers must meet specific provider standards and criteria developed to ensure that AMHH members receive access to a full continuum of behavioral health services provided in a manner that will ensure the health and safety of those individuals. In Indiana, community mental health centers (CMHCs) in good standing with the DMHA are eligible to be approved as IHCP-enrolled AMHH service provider agencies. The application as well as provider agency requirements and expectations are in [Appendix D: CMHC Provider Application and Attestation to Provide AMHH Services](#).

Agency Staff Requirements

A DMHA-approved AMHH provider agency must ensure that the agency staff members providing the AMHH services meet the specific criteria and standards required for the AMHH services they provide. The following sections list agency staff members that may provide AMHH services, as long as the staff member meets the other service-specific criteria required (see *Sections 17-25* of this module for service-specific provider standards and requirements).

Licensed Professionals

The following licensed professionals are eligible to provide AMHH services:

- Licensed physician (including licensed psychiatrist)
- Licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP)
- Licensed clinical social worker (LCSW)
- Licensed mental health counselor (LMHC)
- Licensed marriage and family therapist (LMFT)
- Licensed clinical addiction counselor (LCAC), as defined under *Indiana Code IC 25-23.6-10.5*

Qualified Behavioral Health Professional (QBHP)

A qualified behavioral health professional (QBHP) is defined as any of the following:

- An individual who has had at least 2 years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as previously defined, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
 - In psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana
 - In pastoral counseling from an accredited university
 - In rehabilitation counseling from an accredited university

- An individual who is under the supervision of a licensed professional, as previously defined, is eligible for and working toward licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
 - Social work from a university accredited by the Council on Social Work Education
 - Psychology from an accredited university
 - Mental health counseling from an accredited university
 - Marital and family therapy from an accredited university
- A licensed independent practice school psychologist under the supervision of a licensed professional, as previously defined
- An authorized healthcare professional (AHCP) who is one of the following:
 - A physician's assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of *Indiana Code IC 25-27.5-5*
 - A nurse practitioner or clinical nurse specialist with prescriptive authority and performing duties within the scope of that person's license, under the supervision of or under a supervisory agreement with a licensed physician, pursuant to *IC 25-23-1*

Other Behavioral Health Professional (OBHP)

An Other Behavioral Health Professional (OBHP) is defined as any of the following:

- An individual with an associate's or bachelor's degree, or equivalent behavioral health experience, meeting minimum competency standards set forth by a behavioral health service provider, and supervised by a licensed professional (as previously defined) or a QBHP (as previously defined)
- A licensed addiction counselor, as defined under *IC 25-23.6-10.5*, supervised by a licensed professional, as previously defined, or a QBHP (as previously defined)

AMHH Clinical Supervision Standards

When clinical supervision for provider agency staff is required, it is expected that the provider has and implements clearly delineated policies and procedures for defining, implementing, and documenting clinical supervision, as defined and required by AMHH service standards. Operational supervision is at the discretion of the AMHH provider agency to define and implement.

Section 4: AMHH Member Home and Community-Based Settings Requirements

Adult Mental Health Habilitation (AMHH) is a home and community-based service (HCBS) program. In accordance with federal regulations for 1915(i) State Plan HCBS programs, service activities must be provided within the individual's home (place of residence) or at other locations based in the community. Service activities cannot not be provided in an institutional setting. In addition, members must live in residential settings that meet the requirements of the HCBS settings final rule to be eligible to receive 1915(i) services, including AMHH services.

In January 2014, the Centers for Medicare & Medicaid Services (CMS) published regulations to better define the settings in which states can provide Medicaid HCBS. The [HCBS settings final rule](#) became effective March 17, 2014. The HCBS settings final rule, along with additional guidance and fact sheets, is available on the CMS [Home and Community Based Services Final Regulation](#) page at medicaid.gov/hcbs. According to the CMS final rule on HCBS, service settings must exhibit the following qualities to be eligible sites for delivery of HCBS:

- Are integrated in and support full access to the greater community
- Are selected by the individual from among setting options
- Ensure the individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint
- Optimize autonomy and independence in making life choices
- Facilitate choice regarding services and providers

There are additional requirements for provider owned, controlled, or operated home and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections.
- The individual has privacy in his or her unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit.
- The individual controls his or her own schedule, including access to food at any time.
- The individual can have visitors at any time.
- The setting is physically accessible.

The following are examples of settings that are **not** considered home or community-based:

- Nursing facility
- Institution for mental diseases (IMD)
- Intermediate care facility for individuals with intellectual disability (ICF/IID)
- Hospital
- Any other location that has the qualities of an institutional setting, which may include, but is not limited to:
 - A setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment

- A setting that is located in a building on the grounds of, or immediately adjacent to, a public institution
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS

HCBS Statewide Transition Plan

Indiana has implemented the HCBS Statewide Transition Plan (STP) to ensure that all settings in which HCBS are provided comply with the requirements of the HCBS final rule by the CMS-mandated deadline of March 17, 2019. For more information, and to view the HCBS STP, see the FSSA [Home and Community-Based Services Final Rule Transition Plan](https://www.in.gov/fssa/da) page at [in.gov/fssa/da](https://www.in.gov/fssa/da).

*Note: On May 9, 2017, the CMS offered an extension from the previous deadline of March 17, 2019, to March 17, 2022, to those states that need additional time to comply with the settings requirements of the HCBS final rule. Direction from the CMS is that the implementation of the extension is at the discretion of the State; therefore, DMHA Adult 1915(i) programs (AMHH and Behavioral and Primary Healthcare Coordination [BPHC]) will adhere to the time frames outlined in the STP, which is to maintain the **March 17, 2019**, deadline.*

Additional information for AMHH providers is available on the DMHA [Adult Mental Health and Habilitation Services](https://www.in.gov/fssa/dmha) web page at [in.gov/fssa/dmha](https://www.in.gov/fssa/dmha).

AMHH Members and Choice of Living Arrangement

Many persons choosing to participate in AMHH services live in their own homes, or with families or friends, in the same manner as any adult who does not have a mental illness. Among persons who may be eligible for AMHH services, though, are some who do not have family or friends with whom they can live, or are not functioning at a level in which their health and safety can be supported in a totally independent setting. Depending on a person's level of need and functioning, he or she may choose to live in a full-time supervised setting, a setting that provides less than full-time supervision, or a setting that provides no on-site supervision.

Before an individual selects residential placement, the community mental health center (CMHC) case manager discusses alternatives with the individual, family, and guardian, as applicable. The decision for the choice of placement is based on the individual's identified needs, goals, and resources. After the individual selects his or her placement, an Individualized Integrated Care Plan (IICP) is developed or updated with the individual. The IICP reflects the individual's aspirations and goals for an independent lifestyle and how the residential setting contributes to empowering the individual to continue to live successfully in the community.

The Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) supports a permanent supportive housing model that refers to a housing unit that is linked with community-based services. The tenant holds the lease with a landlord and receives services based on need through a CMHC or community service agency. The tenant's housing is not contingent on the person's participating in any mental health or addiction services. The individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord-tenant law of the State, county, city, or other designated entity. Each individual's essential personal rights of privacy, dignity, respect, and freedom from coercion and restraint are protected.

DMHA-Certified Residential Facility Settings – Standards, Rights, and Definitions

The DMHA-certified residential settings in which some individuals may choose to live promote opportunities that help each individual grow and develop skills needed to continue to live in the community. DMHA-certified residential care settings are a component of an outpatient community-based continuum of care, designed to provide an array of living options that spans the continuum from minimal oversight to highly supervised settings. These settings are not nursing facilities, ICFs/IID, or IMDs. The residential care settings do not have any qualities of an institution, nor would the setting be permitted to be located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or disability-specific housing complex. One of the primary goals of the AMHH service program is to provide services and support to individuals to ensure that they live safely and as independently as possible in the community. The program intends to provide opportunities for individuals to have their needs met in community-based settings and to prevent need for and placement in institutional settings.

The FSSA DMHA and Office of Medicaid Policy and Planning (OMPP) have a strong partnership with State housing agencies: Indiana Housing and Community Development Authority (IHCDA) and Corporation for Supportive Housing (CSH). Together, these agencies have facilitated the development of supportive housing integrated into the community to meet the needs of individuals with mental health and addiction disorders. The DMHA, through certification and licensure standards, require the individual to participate in planning his or her care, supporting the recovery philosophy that promotes the least-restrictive, most-appropriate care to safely meet the individual's identified needs and desires.

The DMHA expects the following standards to be maintained for AMHH members living in a DMHA-certified residential setting (for specific information regarding standards for DMHA-certified residential facilities, see *Indiana Administrative Code 440 IAC 7.5, Residential Living Facilities for Individuals with Psychiatric Disorders or Addictions*):

- Residential settings should comprise individual- or single-occupancy dwellings or residences. Residential settings should promote opportunities to help each individual grow and develop skills needed to continue to live in the community.
- While the individual lives in a DMHA-certified residential facility, the provider's responsibility is to ensure that the resident is involved in decisions that affect the resident's care, daily schedules, and lifestyles.
- The overall atmosphere of the setting is conducive to the resident achieving optimal independence, safety, and development, with the resident's input.
- The location of the facility provides reasonable access to the community at large, including but not limited to:
 - The provider agency
 - Medical, recreational, and shopping areas
 - Public or agency-arranged transportation
- The location, design, construction, and furnishings of each residence must be consistent with a family or personal home (homelike).
- The majority of services and behavioral healthcare is provided in locations outside the residence, such as in the community at large or in a clinic setting.
- Residents are afforded the opportunity to engage in community-based programs that assist in achieving goals, including employment.

Within AMHH, the State defines homelike as *an atmosphere with patterns and conditions of everyday life that are as close as possible to those of individuals without diagnoses of mental illness*. This definition includes an environment designed to increase the resident's involvement in decisions that affect his or her care, daily schedule, and lifestyle, so the settings are similar to those of the resident's peers who live on their own. The overall atmosphere of the setting is conducive to the resident achieving independence. The location of the facility provides residents reasonable access to the community at large, including but not limited to the provider agency and medical, recreational, and shopping areas via public or agency-arranged transportation.

In addition to the rights and responsibilities listed in *IC 12-27*, an AMHH member living in a DMHA-certified residential setting has the following rights, as documented in *440 IAC 7.5-2-6*:

- The environment is safe.
- Each resident is free from abuse and neglect.
- Each resident is treated with consideration, respect, and full recognition of the resident's dignity and individuality.
- Each resident is free to communicate, associate, and meet privately with persons of the resident's choice, as long as the exercise of these rights does not infringe on the rights of another resident, and any restriction of this right is a part of the resident's IICP.
- Each resident has the right to confidentiality concerning personal information, including health information.
- Each resident is free to voice grievances and to recommend changes in the policies and services offered by the agency.
- Residents are not required to participate in research projects.
- Each resident has the right to manage personal financial affairs or to seek assistance in managing them, unless the resident has a representative payee or a court-appointed guardian for financial matters.
- Each resident must be informed about available legal and advocacy services, and may contact or consult legal counsel at the resident's own expense.
- Each resident must be informed of the number for DMHA's toll-free consumer service telephone line.

Any modification of the resident's rights must be supported by a specific assessed need and documented in the person-centered IICP as follows:

- Identify the specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- Document less-intrusive methods of meeting the need that have been tried but did not work.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine whether the modification is still necessary or can be terminated.
- Include the informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

The community residential settings certified by the DMHA and identified in the AMHH State Plan Amendment (SPA) as meeting the standard for community living include:

- A supervised group living facility
- A transitional residential services facility
- A semi-independent living program facility defined under *Indiana Code IC 12-22-2-3*
- Alternative family homes operated solely by resident householders

Supervised Group Living (SGL) Facility

A supervised group living (SGL) facility is defined by the DMHA as a residential facility that provides a therapeutic environment in a homelike setting to persons with a psychiatric disorder or addiction who need the benefits of a group living arrangement as post-psychiatric hospitalization intervention or as an alternative to hospitalization. *Therapeutic environment* means a living environment in which the staff and other residents contribute, and that presents no physical or social impediments to the habilitation and rehabilitation of the resident.

An SGL setting is designed to assist individuals in the recovery process by offering a safe, supportive, homelike environment. On-site supervision is required 24 hours a day, 7 days a week in this setting. Individuals may come and go as needed to attend work, school, treatment appointments, recreation, and so on. Individuals have access to food 24 hours a day, 7 days a week, but there are also typically planned meal times when individuals may eat together. Menus are developed by dietitians to provide healthy meals that are consistent with each individual's dietary needs and restrictions (for example, diabetic or low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Clients have input in meal planning.

A certified SGL facility serves up to 10 clients in a single-family dwelling and up to 15 clients in an apartment building (three or more living units) or in a congregate residence.

Transitional Residential Services (TRS) Facility

A transitional residential services (TRS) facility is defined by the DMHA as a 24-hour per day service that provides food, shelter, and other support services to individuals with a psychiatric disorder or addiction who are in need of a short-term supportive residential environment.

A certified TRS facility serves 15 or fewer persons. Individuals in this setting are likely preparing for, or already participating in, work or school activities and are not supervised 24 hours a day. Individuals have input into household activities and may come and go as needed to attend work, school, treatment appointments, recreation, and so on. Individuals have access to food 24 hours a day, 7 days a week, but there are also typically planned meal times when individuals may eat together. Menus are developed by dietitians to provide healthy meals that are consistent with each individual's dietary needs and restrictions (for example, diabetic or low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Clients have input in meal planning.

Semi-Independent Living Program (SILP) Facility

A semi-independent living program (SILP) facility is defined by the DMHA as:

- A facility that is not licensed by another State agency and serves six or fewer individuals per residence who have psychiatric disorders or an addiction, or both, and who require only limited supervision
- A facility in which the agency or its subcontractor provides a resident living allowance to the resident; or owns, leases, or manages the residence

SILP facility settings are typically homelike. This setting is intended to prepare individuals for independent living settings. Individuals in this type of setting are provided with a minimum of oversight (that is, 1 hour per week). Individuals have input into household activities and may come and go as needed to attend work, school, treatment appointments, recreation, and so on. Individuals have access to food 24 hours a day, 7 days a week, but there are also typically planned meal times when individuals may eat together. Menus are developed by dietitians to provide healthy meals that are consistent with each individual's dietary needs and restrictions (for example, diabetic or low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Clients have input in meal planning.

Alternative Family for Adults (AFA) Program Homes

An alternative family for adults (AFA) program is defined by the DMHA as *a program that serves six or fewer individuals who have psychiatric disorders or addictions, or both, and reside with an unrelated householder.*

AFA program settings are homelike. The setting is intended to prepare individuals for independent living, or may become permanent housing if the AFA home best meets the individual's needs and a less-restrictive setting is not wanted or deemed appropriate by the individual or treatment team. Individuals in this type of setting are provided with a minimum of oversight (that is, 2 hours per month). Individuals have input into household activities and may come and go as needed to attend work, school, treatment appointments, recreation, and so on. Individuals have access to food 24 hours a day, 7 days a week, but there are also typically planned meal times when individuals may eat together. Menus are developed by dietitians to provide healthy meals that are consistent with each individual's dietary needs or restrictions (for example, diabetic or low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Clients have input in meal planning.

State Monitoring

The DMHA retains the authority to monitor and enforce adherence to standards by conducting on-site visits to ensure compliance with standards and respond to any complaint or incident reported. In addition to client feedback and site visits, data is collected and analyzed in accordance with the *Quality Indicator* section of the AMHH SPA. There are also facility requirements for compliance with fire and safety codes, which must be up to date. The DMHA conducts site visits to ensure that standards are met. Individuals residing in any DMHA-certified residential setting have the freedom to choose how they live, and residents' rights are respected and honored.

The Indiana HCBS STP describes how the State Evaluation Team (SET) will conduct ongoing monitoring of settings that were identified by AMHH or BPHC enrolled providers and assessed by the DMHA SET. Beginning state fiscal year (SFY) 2018, the SET assessed those AMHH or BPHC provider owned, controlled, or operated (POCO) residential and POCO nonresidential settings that required physical changes to their setting to meet the CMS HCBS requirements. Those physical changes, for example, could be adding locks on bathroom and bedroom doors and/or posting and/or updating documents in the setting. For those HCBS compliant settings that did not require physical changes, the POCO residential and POCO nonresidential settings will be monitored to ensure the HCBS requirements remain in compliance. When possible, the SET will schedule their setting(s) site visit with the agency's annual DMHA Adult 1915(i) quality assurance (QA)/quality improvement (QI) visit. When this is not feasible, the SET will work with the provider to schedule another time to conduct the setting(s) visit. As of December 2018, all POCO settings were visited that required physical remediation and were determined fully compliant with the HCBS Final Rule.

All settings in which an HCBS member resides or receives HCBS services must fully comply with CMS settings regulation. For this reason, setting assessments are not limited to only those POCO settings owned, controlled, or operated by CMHCs. AMHH and BPHC provider agencies must ensure that all settings where HCBS members reside (CMHC POCO, non-CMHC POCO, and non-POCO) meet the intent of the regulation. The DMHA SET will make the final determination of the setting compliance.

Incident Reporting

Incident reporting provides a mechanism for reporting and responding to critical or sentinel incidents occurring in connection with the AMHH program. Provider agencies are required to follow the DMHA requirements on critical incident reporting:

- For POCO residential settings, providers are required to report incidents within 24 hours of the incident.
- For community-based settings, providers are required to report these incidents within 72 hours of becoming aware of the incident.

The DMHA developed the online [Critical Incident Reporting](#) portal for submitting incident reports. For all critical incidents involving members receiving AMHH services, an incident report must be submitted with the appropriate box selected indicating that the member is receiving AMHH services. When a provider submits a report to the portal with the AMHH Services checkbox selected, the system automatically sends the report to the AMHH/BPHC mailbox. The SET uses this data to report to the CMS.

Section 5: AMHH Program Member Eligibility

Adult Mental Health Habilitation (AMHH) services are offered as part of a Medicaid State Plan option for providing 1915(i) home and community-based services (HCBS) to promote and empower independence and integration into the community as an alternative to an institutional level of care. This 1915(i) option allows Indiana to offer HCBS to individuals who are enrolled in Medicaid and meet specific target-group and needs-based eligibility criteria. As defined in the AMHH State Plan Amendment (SPA) and in *Indiana Administrative Code 405 IAC 5-21.6*, Indiana elected to target the 1915(i) State Plan HCBS benefit to a specific population.

Eligibility for the AMHH program is determined by the State Evaluation Team (SET) and is based on the following:

- Target-group criteria
- Financial criteria (enrolled in Medicaid)
- Needs-based criteria

Eligibility Determination and Conflict of Interest

To prevent conflict of interest in the final AMHH eligibility determinations, the responsibility for AMHH program eligibility determination and approval of the proposed AMHH services is in all cases retained by the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) State Evaluation Team (SET). Members of the SET are prohibited from having any financial relationships with the applicant or member requesting AMHH services, the families, or the provider agency selected to provide AMHH services.

AMHH provider agencies are required to have written policies and procedures that address conflicts of interest available for review by the State. These policies and procedures must clearly define and describe how conflict of interest requirements are implemented and monitored within the agency to ensure protection of the individuals applying for AMHH services and the integrity of the AMHH program.

Member Eligibility Criteria

The applicant must meet the following target-group and needs-based criteria to be eligible to receive AMHH services.

Target-Group Criteria

AMHH services are targeted for individuals who meet all the following target-group criteria:

- The individual is enrolled in an eligible Indiana Health Coverage Programs (IHCP) Medicaid program.
- The individual is age 35 or older at time of initial application.
- The individual has an AMHH-eligible primary mental health diagnosis, which may include the following:
 - Schizophrenic disorders (ICD-10 code: F20.xx)
 - Schizoaffective disorders (ICD-10 code: F25.x)
 - Manic episodes (ICD-10 code: F30.xx)
 - Major depressive disorders (ICD-10 code: F33.x)

- Bipolar disorders (ICD-10 code: F31.xx)
- Delusional disorders (ICD-10 code: F22)
- Psychotic disorders, unspecified (ICD-10 code: F29)
- Obsessive-compulsive disorders (ICD-10 code: F42.x)

(See *Adult Mental Health Habilitation Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers, for a full listing of AMHH-eligible diagnosis codes.)

Needs-Based Criteria

In addition to meeting the AMHH target-group criteria, the applicant must also meet all the following needs-based criteria to be eligible for AMHH services:

- Without ongoing habilitation services as demonstrated by written attestation by a psychiatrist or health services provider in psychology (HSPP), the applicant is likely to deteriorate and be at risk of institutionalization (for example, acute hospitalization or time spent in a state hospital, nursing home, or jail).
- The applicant must demonstrate the need for significant assistance in major life domains related to his or her mental illness (for example, physical problems, social functioning, basic living skills, self-care, and potential for harm to self or others). *Significant* means an assessed need for immediate or intensive action due to a serious or disabling need. *Assistance* means any kind of support from another person (for example, mentoring, supervision, reminders, verbal cueing, or hands-on assistance) needed because of a mental health condition or disorder.
- The applicant must demonstrate significant needs related to his or her behavioral health.
- The applicant must demonstrate significant impairment in self-management of his or her mental illness or demonstrate significant needs for assistance with mental illness management.
- The applicant must demonstrate a lack of sufficient natural supports to assist with mental illness management.
- The individual is not a danger to self or others at the time the application for AMHH program eligibility is submitted for SET review and determination.
- The individual has a recommendation for intensive community-based care on the Adult Needs and Strengths Assessment (ANSA) tool, with a level 4 or higher. See [Section 6: AMHH Referral and Application Process](#) for additional information about the assessment tool.

An applicant not meeting the target-group and needs-based criteria as previously defined will not be eligible to receive AMHH services under the 1915(i) HCBS State Plan option. When applicable, ineligible applicants will be referred to services that may meet their needs.

Section 6: Member Application for AMHH Program

For an individual to receive Adult Mental Health Habilitation (AMHH) services, a Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA)-approved AMHH provider agency, in collaboration with the individual seeking services, must refer the individual for evaluation by the State Evaluation Team (SET) via a web-based application process in the manner required by the FSSA Office of Medicaid Policy and Planning (OMPP) and DMHA. AMHH services will not be authorized for any individual who has not successfully completed the AMHH application process or does not meet all AMHH eligibility criteria, as determined by the DMHA SET. This section outlines the referral process and provider agency responsibilities during the application process. For specific instructions for completing the AMHH application, see [Section 10: AMHH Service Eligibility – Initial AMHH Application](#) in this module.

Referrals for AMHH Services

Referrals to AMHH services may come from any source within the community:

- Community mental health centers (CMHCs) or other treatment providers may identify individuals who appear to meet the AMHH target-group and needs-based eligibility criteria.
- Individuals may notify a DMHA-approved AMHH provider of interest in AMHH services.
- Family members or caregivers may inquire about the services and assist the family member in contacting a DMHA-approved AMHH provider.

Note: The AMHH referral process may begin while an applicant is in an institutional setting (for example, in a State-operated facility, or SOF) as part of discharge planning and continuity of care. However, AMHH services may not begin until the individual has been discharged to a community-based setting.

Information about AMHH services may be obtained on the DMHA [Adult Mental Health Habilitation Services](#) page at in.gov/dmha. The web page provides a summary of eligibility criteria and a description of all available AMHH services, as well as a list of AMHH service provider agencies, locations where potential enrollees may apply, and information about how to access AMHH assessments or services. In addition, any individual may contact the State for information about AMHH eligibility and the application process. In those cases, to help with the application process, the DMHA provides the individual with a list of DMHA-approved AMHH provider agencies.

Before completing the AMHH application process, the DMHA-approved AMHH provider explains the benefits and purpose of the AMHH program and services with the interested applicant. Next, the provider helps determine whether the applicant meets the AMHH target-group and needs-based criteria. If the applicant meets initial eligibility criteria and is interested in pursuing an application for AMHH services, the AMHH provider works with the applicant to complete the AMHH application process.

Provider Agency Responsibilities during the Application Process

Provider agencies have a number of responsibilities during the application process.

Informed Choice of Providers

The DMHA-approved AMHH provider agency is responsible for informing the applicant of his or her right to select an AMHH provider. During the AMHH application process, the provider agency is responsible for performing the following tasks and documenting the activities intended to educate the applicant regarding the applicant's informed choice of providers:

- Explain the applicant's right to an informed choice of providers, meaning the applicant is informed of his or her right to interview potential AMHH service providers and decide which agency and which staff within that agency will provide the AMHH services documented on the proposed Individualized Integrated Care Plan (IICP), and to choose which family members or caregivers, if any, will be involved as members of the individual's care team.
- Provide a list of DMHA-approved AMHH provider agencies in the applicant's county of residence and in counties contiguous to the applicant's county of residence. The agency provides a randomized list of DMHA-approved AMHH provider agencies for the applicant to select from when developing the application. The choice is documented via an attestation in the AMHH application.
- Inform the applicant that an AMHH provider agency listing is also posted on the DMHA [Adult Mental Health Habilitation Services](http://in.gov/dmha) page at in.gov/dmha.
- Inform the applicant of his or her right to change the AMHH provider staff or agency any time during the applicant's AMHH program eligibility. The current AMHH provider is expected to assist the individual in transitioning service delivery to the newly selected AMHH provider.

Requirement for Face-to-Face Evaluations

Every AMHH applicant is required to receive an individual face-to-face evaluation as the foundation of the application process, using both the DMHA-approved behavioral health assessment tool (the Adult Needs and Strengths Assessment, or ANSA) and the application form developed by the FSSA (OMPP and DMHA). A comprehensive biopsychosocial evaluation is conducted by provider agency staff qualified to conduct AMHH assessments; see [Section 8: Behavioral Health Assessment Tool \(ANSA\)](#). The results of the evaluation and the ANSA assessment are included with the AMHH application.

Documentation of the individual face-to-face evaluation in the applicant's clinical record must include the following:

- Clear documentation that the AMHH evaluation was conducted face-to-face with the client
- Review, discussion, and documentation of the applicant's desires, needs, and goals (*Note: Goals are habilitative in nature with outcomes specific to the habilitative needs identified by the applicant.*)
- Review of psychiatric symptoms and how the symptoms affect the applicant's functioning and ability to attain desires, needs, and goals
- Review of the applicant's skills and the level of support needed for the applicant to participate in a long-term recovery process, including stabilization in the community and ability to function in the least-restrictive living, working, and learning environments
- Review of the applicant's strengths and needs, including medical, behavioral, social, housing, and employment

Only qualified and trained staff from DMHA-approved AMHH provider agencies may conduct the face-to-face evaluation required for the AMHH application process. The AMHH provider agency must ensure that the agency staff member providing the face-to-face AMHH evaluation meets the following minimum qualifications:

- Possesses at least a bachelor's degree in social sciences or related field, with 2 or more years of clinical experience. Clinical experience may be obtained before or after the attainment of the required degree.
- Has completed the FSSA (DMHA and OMPP)-approved training for the AMHH eligibility determination, application process, and service delivery standards. It is the responsibility of the CMHC to ensure that appropriate documentation is in the staff file demonstrating compliance with training requirements.
- Is a certified ANSA user receiving supervision from an ANSA SuperUser

Proposed AMHH Plan of Care

The agency provider staff member and the applicant, as well as individuals the applicant chose to be an active part of the team, jointly develop a proposed IICP. The proposed IICP includes the applicant's identified strengths and needs, desired goals, and choice of providers and services (including proposed AMHH services) deemed necessary to address the documented goals. For additional information regarding person-centered planning and the AMHH IICP requirements and expectations, see [Section 9: Individualized Integrated Care Plan \(IICP\) Development for AMHH Services](#).

Completing and Processing the AMHH Member Application

The AMHH agency staff member completes and submits the AMHH application via the DMHA's web-based Data Assessment Registry Mental Health and Addiction (DARMHA) system. The application must be completed and submitted in its entirety for eligibility determination by the SET. Elements of the AMHH application include:

- The applicant's identifying and eligibility information
- A description of the applicant's living situation, including whether the applicant's living situation meets Home and Community-Based Services (HCBS) settings requirements
- Justification of the need for AMHH services
- The applicant's strengths
- The applicant's needs
- The applicant's goals
- The applicant's objectives
- The applicant's requested services
- Attestations

Note: The AMHH application must be submitted with a completed attestation that includes the dates the required signatures were obtained. The required signatures must have been obtained within 60 calendar days prior to the application being submitted, and must be maintained in the AMHH member's clinical record. The signatures are subject to review by the SET during AMHH quality assurance site visits.

For further information about required attestations, as well as instructions on how to complete the AMHH application, see [Section 10: AMHH Service Eligibility – Initial AMHH Application](#).

After a complete AMHH application is submitted through the DARMHA, the SET evaluates the application and determines whether the applicant meets eligibility for the AMHH program. Eligibility determinations for the AMHH program are made exclusively by the SET to avoid any potential conflicts of interest with persons performing evaluations, assessments, and IICPs. For specific information about SET determinations, see [Section 11: AMHH Service Eligibility and Authorizations](#).

All required fields must be filled out on the AMHH application or it will not be accepted. If all fields are completed but there is insufficient or inconsistent information for a clinical determination to be made, the SET may deny or pend the application and request additional information from the AMHH provider agency.

If the application is placed in the pending status and the required information is not submitted in DARMHA within 7 calendar days of the team's request, the AMHH application will be subject to denial. However, the provider agency may submit an updated AMHH application at a later date for team consideration. To ensure no conflict of interest in the AMHH clinical eligibility determination, the DMHA SET will retain the authority to determine an applicant's clinical eligibility for the AMHH program and authorization to utilize the AMHH services.

Tracking AMHH Application Status

The status of an AMHH application can be tracked in DARMHA. A full listing of the application status codes are found in [Appendix E: AMHH Application Status Codes](#). The status code is updated whenever a new action is taken on an AMHH application. Providers are responsible for monitoring the status of each submitted AMHH application to ensure timely processing. Providers must routinely use this code to track where an application is in the process of program eligibility determination to ensure timely processing of each application. Tracking the progress of an AMHH application is an administrative function, not an AMHH service activity.

Section 7: Completing the HCBS Residential Setting Screening Tool

Members who receive services through the Adult Mental Health Habilitation (AMHH) program are required to live in settings that meet federal Centers for Medicare & Medicaid (CMS) requirements for home and community-based services (HCBS) (see [Section 4: AMHH Member Home and Community-Based Settings Requirements](#) in this module). Members who live in an institutional setting are not eligible to receive AMHH services. Institutional settings are defined as the following:

- *Nursing Home*: Care provided 24 hours a day, 7 days a week in a skilled nursing facility
- *Hospital*: Care provided 24 hours a day, 7 days a week in an inpatient psychiatric hospital, psychiatric health facility (such as a stress center), general hospital, private adult psychiatric hospital, Veterans Affairs hospital, State-operated facility (SOF), or transitional care hospitals
- *Institute for mental disease (IMD)*: Care provided 24 hours a day, 7 days a week in an IMD
- *Intermediate care facility for individuals with intellectual disability (ICF/IID)*: Care provided 24 hours a day, 7 days a week in an ICF/IID
- *Jail/Correctional Facility*: Home detention, detention centers, work release, weekend jail, boot camp, jail, correctional facility, or prison

The Residential Setting Screening Tool (RSST) ensures that the residential settings in which applicants for AMHH services live are assessed for compliance with the HCBS settings final rule. The AMHH provider agency, in collaboration with the individual seeking services, must complete the HCBS RSST developed by the Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) and the FSSA Division of Mental Health and Addiction (DMHA) for every AMHH application submitted through Data Assessment Registry Mental Health and Addiction (DARMHA).

The RSST is intended to:

- Help members and providers identify the type of *community-based* setting in which a member lives.
- Assess whether that setting meets HCBS criteria, as defined by the HCBS settings final rule.
- Select the appropriate response for the *Current Living Situation* section of the AMHH application in DARMHA.
- Provide required information about the compliance status of the setting (see [Section 10: AMHH Service Eligibility – Initial AMHH Application](#) in this module).

Accessing and Using the RSST

The RSST must be completed during the assessment process for every AMHH application (initial, renewal, or modification). The RSST must be completed **before** creating the AMHH application in DARMHA, to ensure that correct information is reported on the AMHH application. A completed copy of the tool, with the member and staff signature, must be kept with the member's clinical record for later review by the DMHA State Evaluation Team (SET).

The most current version of the HCBS RSST is available for download on the DMHA [Home- and Community-Based Services](#) page at in.gov/fssa/dmha. Included with the RSST is a companion document that provides general instructions, definitions of terms used in the tool, and additional information for members and provider staff completing the tool. Specific instructions and directions are located in each section of the RSST.

After the member's identifying information is entered in the top section, the remaining sections of the RSST are completed, in order, until the member's community-based living situation has been accurately identified and assessed. Both the staff and the member must sign, date, and print his or her name in the appropriate section. The outcome from the RSST must be entered into the *Current Living Situation* section of the member's AMHH application in DARMHA (see [Section 10: AMHH Service Eligibility – Initial AMHH Application](#) in this module).

Providers are not required to submit an updated RSST to DMHA each time a member moves to a new address. However, providers are still required to complete a new RSST with the member each time a member moves to a new address. This new RSST must be kept in the member's clinical record.

Definitions Used in the RSST

The following sections define the terms used in Sections 1–5 of the current RSST (see [Appendix G: HCBS Residential Setting Screening Tool](#)).

Homeless

Homeless is defined as:

- Lacking a fixed, regular, and adequate nighttime residence, and/or
- The primary nighttime residence is:
 - A supervised publicly or privately operated shelter designed to provide temporary living accommodation of 3 or less months, or
 - A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (for example, on the street)

Note that this definition includes members who temporarily reside in homeless shelters.

Private/Independent Home

An individual's private home (owned or leased), or a relative's home (owned or leased) where the individual resides, is considered to be a *private/independent home*. According to the CMS, a state may presume that an individual's private home or a relative's home where an individual resides meets the home and community-based settings requirements; however, it is still the state's responsibility to ensure that individuals living in a private home or a relative's home have opportunities for full access to the greater community.

Four characteristics must be present at a private/independent home:

- The residence is owned or leased/rented by the member or someone in the member's family for his or her personal use.
- The residence affords opportunities for full access to the greater community.
- The residence is not owned or operated by an agency which provides AMHH and/or BPHC services.
- The residence is not located in or on the grounds of a hospital, nursing home, or other facility that provides inpatient institutional care.

Presumed Institutional Setting

Some residential settings are presumed to have qualities of an institution, based on the following characteristics:

- The residence is located in a publicly or privately owned facility that also provides inpatient institutional care.

- The residence is in a building on the grounds of, or immediately adjacent to, a public institution.
- The residence has the effect of isolating individuals receiving AMHH services from the broader community.

CMHC Provider Owned, Controlled, or Operated (POCO) Residential Setting

A *CMHC POCO residential setting* is a specific physical place where a member lives that is owned, leased, or co-leased by a CMHC provider of HCBS. Examples of CMHC POCO residential settings are as follows:

- Supervised group living facilities
- Transitional residential services facilities
- Semi-independent living program facilities defined under *Indiana Code IC 12-22-2-3*
- Alternative family homes operated solely by resident householders

Non-POCO Residential Setting

The DMHA uses the term *non-POCO residential settings* to refer to settings owned, controlled, or operated by either a not-for-profit organization or an independent setting operating authority rather than a CMHC. Examples of these types of residential settings include but are not limited to the following:

- Residential care facilities (RCFs); this category includes unlicensed assisted living facilities (ALFs) and adult family care homes (AFCHs)
- County homes
- Cluster homes or cluster apartments owned by nonprofit agencies

Non-CMHC POCO Residential Setting

A *non-CMHC POCO residential setting* is a specific physical place where a member lives that is owned, leased, or co-leased by a provider of HCBS *other than a CMHC*. However, these may be considered POCO residential settings under the authority of other FSSA Divisions.

The Indiana FSSA Division of Aging (DA) and Division of Disability and Rehabilitative Services (DDRS) administer four other Medicaid HCBS programs, known as 1915(c) Home and Community-Based Services Waivers:

- Traumatic Brain Injury (TBI) Waiver, administered by the DA
- Aged and Disabled (A&D) Waiver, administered by the DA
- Community Integration and Habilitation (CIH) Waiver, administered by the DDRS
- Family Supports Waiver (FSW), administered by the DDRS

A member receiving services under any of these 1915(c) waivers also must live in a setting that is HCBS compliant.

Section 8: Behavioral Health Assessment Tool (ANSA)

The Adult Needs and Strengths Assessment (ANSA) is the Division of Mental Health and Addiction (DMHA)-approved behavioral health assessment tool that identifies an applicant's strengths and needs, and is used to help determine an individual's level of need for Adult Mental Health Habilitation (AMHH) services. The tool consists of items grouped into categories (domains) that the provider agency staff member assesses and discusses with the applicant during the face-to-face biopsychosocial assessment. The combined ratings resulting from the completed ANSA tool generate a level-of-care recommendation that may be used to support a recommendation for AMHH services.

The level-of-need recommendation from the ANSA tool is not intended to be a mandate for the level of services that an individual receives but is one element used in the final eligibility decision made by the State Evaluation Team (SET). Many factors, including an individual's preferences and choice, influence the actual intensity of the treatment services recommended on the applicant's proposed Individualized Integrated Care Plan (IICP).

To be considered current, the DMHA-approved behavioral health assessment tool (ANSA) must be completed and submitted in the Data Assessment Registry Mental Health and Addiction (DARMHA) within 60 days before submitting the AMHH initial or renewal application. Data from the most recent ANSA at the time the application is created populates the AMHH application, regardless of the "age" of that ANSA. If the ANSA is more than 60 days old, the application will be denied by the SET.

Providers may obtain additional information about the ANSA tool, and ANSA training, support, and certification by contacting the DMHA. The [DARMHA website](https://dmha.fssa.in.gov/darmha) at dmha.fssa.in.gov/darmha contains the most up-to-date ANSA user manual.

Section 9: Individualized Integrated Care Plan Development for AMHH Services

Person-centered planning is an existing expectation of the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) for provider agencies in Indiana. This requirement is supported by community mental health center (CMHC) certification rules, requirements for national accreditation, and contracts connected to DMHA funding and is required according to *Code of Federal Regulations 42 CFR part 441.725*. The member has the freedom to choose who is included in developing the Individualized Integrated Care Plan (IICP). IICPs require staff and member signatures, as well as clinical documentation verifying the member's participation. This section outlines the requirements for the proposed IICP developed during the AMHH member application process and maintained throughout the member's enrollment in AMHH services.

Staff Requirements

All AMHH IICPs must be developed in collaboration with an AMHH provider agency staff member who meets one of the following minimum certification requirements:

- Licensed professional
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

For details regarding minimum staffing requirements, see [Section 3: AMHH Agency Staff Requirements](#).

AMHH services psychiatrists or health service providers in psychology (HSPPs) must be enrolled in the IHCP as rendering providers and be linked to the AMHH provider agency. The State expects the psychiatrist or HSPP to complete the following:

- Review the AMHH member application and assess the information for accuracy.
- Approve and certify the proposed AMHH diagnosis. See *Adult Mental Health Habilitation Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.
- Attest and deem that the recommended AMHH services on the proposed IICP are clinically indicated and medically necessary and follow the Centers for Medicare & Medicaid Services (CMS) requirements for person-centered planning.
- Attest that without ongoing habilitation services, the applicant will likely deteriorate and be at risk of institutionalization (for example, acute hospitalization, State hospital, nursing home, or jail).
- Attest that the applicant is not a danger to self or others at the time of this application.

Freedom of Choice

The AMHH member has freedom of choice regarding the following:

- Whether to participate in the AMHH program
- The team members who participate in the development and implementation of the IICP, regardless of funding sources
- The goals and objectives documented on the proposed IICP

- The AMHH services requested by the member on his or her proposed IICP, as supported by the member's documented needs, goals, and desires
- The selection of DMHA-approved AMHH service providers that will deliver AMHH services

Reminder: AMHH members have the right to request a change of AMHH providers at any time during the AMHH eligibility period.

Developing the Individualized Integrated Care Plan

A proposed AMHH IICP must be developed for each member through a collaboration that includes the applicant or member and his or her chosen representatives, such as community supports, family and nonprofessional caregivers, natural/unpaid supports, and any individuals and agency staff involved in assessing and providing care for the applicant or member that the member wishes to include in the IICP. The IICP is a habilitative plan of care that integrates all components and aspects of care that:

- Are clinically indicated and deemed medically necessary
- Are supported by the member's identified needs, goals, and desires
- Are provided in the most appropriate, least-restrictive Home and Community-Based Services (HCBS) setting for achieving the applicant's or member's goals
- Include all indicated medical and support services, paid or unpaid, and regardless of funding sources needed by the member to remain in the community and function at the highest possible level of independence

The AMHH staff must ensure that the IICP development is driven by a person-centered planning process that incorporates the following IICP standards:

- Identifies the member's physical and behavioral health support needs, strengths, preferences and desired outcomes
- Takes into account the extent of, and need for, any family or other natural supports for the individual
- Prevents the provision of unnecessary or inappropriate services or care
- Is guided by best practices and research on effective strategies for improved health and quality of life
- Reflects a plan of care developed for the member with the member and represents the member's desires and choices for care

The IICP must include all identified services medically necessary to help the applicant or member continue to reside in the community, to function at the highest level of independence possible, and to achieve his or her goals. The following must be documented on the IICP:

- The goals the member chose that promote stability and support continued integration into the community, treatment of mental illness, and habilitation of functional deficits related to the mental illness (including co-occurring serious mental illness, or serious mental illness [SMI], and substance use disorders)
- Individuals and teams responsible for treatment, coordination of care, linkage, and referrals to internal as well as external resources and care providers to meet identified needs
- Identifies by title the AMHH services the applicant or member needs and has indicated as a desired service on the proposed IICP
- A list of all other services and supports that will be delivered in conjunction with the proposed AMHH services

Note: The primary distinction between the AMHH habilitation services and the Medicaid Rehabilitation Option (MRO) rehabilitation services is the IICP treatment goals. The MRO program's philosophy is that the individual will improve his or her level of functioning over time. The AMHH philosophy is that the IICP goals address reinforcement, management, adaptation, and retention of a level of functioning.

The IICP must be finalized and agreed to, with the informed consent of the applicant or member in writing, and signed by all individuals and providers responsible for the IICP implementation. A copy of the IICP must be offered to the member and/or legal guardian and other individuals involved in the plan.

Crisis Plan

AMHH members must be deemed stable enough to benefit from intensive home and community-based habilitation services. However, the target population is generally considered vulnerable and susceptible to crises. To ensure a member's safety and successful utilization of AMHH services, a crisis plan is an important part of treatment planning and a requirement for all members receiving AMHH services. The crisis plan is created based on client-focused triggers and identifies means to deal with potential crises that put the client at risk of hospitalization or institutionalization if the crisis is not mitigated or averted. The plan puts in place supports to help the member avoid or cope with identified triggers that typically result in crises for the member. The AMHH provider agency, in conjunction with the member, must develop and/or update a crisis plan for every AMHH application submitted to DMHA and maintain the plan in the client's electronic medical record. The information and resources in this section will help providers guide the member in developing an individualized crisis plan.

The crisis plan should also pertain to/include non-mental-health/substance-use challenges that create or have created crisis situations in the individual's life. The following is required of the provider agency when developing the crisis plan:

- The crisis plan must be developed with the member/legal guardian (and family or caregiver, if applicable).
- The plan should reflect the choice and preferences of the member/legal guardian (and family or caregiver, if applicable).
- Submission of the crisis plan document to the State Evaluation Team (SET) is optional, but in all cases, the crisis plan must be maintained in the clinical record and made available for review by the DMHA.
- Potential crises that have been identified and documented during the face-to-face evaluation and while developing the proposed IICP, as well as the member, family, or caregiver reports of past crisis situations, if applicable
- Indicators of emerging risks, impending crises, and increased levels of risk
- Crisis-defusing strategies to which the member has responded well in the past, as well as action steps to prevent or mitigate potential identified crises
- Individuals and resources that can help the member complete the steps documented in the crisis plan (for example, family, natural supports, community resources, and formal supports). These resources should also include a contingency plan if an identified resource or individual cannot be accessed during the crisis.

Note: AMHH services (for example, Respite Care or Peer Support) may be added to the proposed IICP to build coping skills, defuse crises, or provide support during a crisis.

Member's Refusal to Sign the IICP

The IICP must reflect the member's desires and choices. The member's signature, demonstrating his or her participation in the development of initial and ongoing IICP reviews, is required on the proposed IICP submitted to the SET for review and approval. Infrequently, a member may request services but refuse to sign the IICP for various reasons (thought disorder, paranoia, and so on). If a member refuses to sign the IICP, the agency staff member is required to document on the plan of care that the member agreed to the plan but refused to sign it. The agency staff member must also document in the clinical record progress note that a planning meeting with the member did occur and that the IICP reflects the member's choice of services and his or her agreement to participate in the services identified in the IICP. The progress note must further explain any known reasons why the member refused to sign the plan and how those issues will be addressed in the future.

Ongoing IICP Review

The provider agency is responsible to ensure that a member's progress and movement toward attaining the IICP goals is monitored on a regular basis, and that the IICP continues to reflect the member's identified strengths, needs, goals, and preferences. At minimum, the IICP must be reviewed every 90 days as part of the member's regular 90-day treatment review. If additional AMHH services are warranted, an updated proposed IICP requesting new service authorizations must be submitted to the SET. An IICP cannot be updated without the member's consent and knowledge. Delivery of the proposed new AMHH services may not commence until SET approval has been granted. For more information, see [Section 13: AMHH Eligibility Period and Renewal of Eligibility](#).

Section 10: AMHH Service Eligibility – Initial AMHH Application

For an individual to receive Adult Mental Health Habilitation (AMHH) services, an AMHH provider agency, in collaboration with the individual seeking services, must submit an application as required by the Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) and FSSA Division of Mental Health and Addiction (DMHA). This section provides instructions for completing the AMHH application in the Data Assessment Registry Mental Health and Addiction (DARMHA).

Required Activities before Creating an AMHH Application

Before an AMHH application is created in DARMHA, several activities must be completed, and documentation that the activities occurred must be retained in the applicant's clinical record. These activities include:

- Completion of a face-to-face evaluation by AMHH qualified staff to determine the applicant's biopsychosocial needs for the program.
- Completion of an Adult Needs and Strengths Assessment (ANSA), based on a face-to-face interview with the applicant by a qualified ANSA user. The ANSA must have been completed and submitted in DARMHA within 60 days of the AMHH application submission and must include a recommended level of need (LON).
- Completion of the Home and Community-Based Services (HCBS) Residential Setting Screening Tool (RSST) with the applicant; see [Section 7: Completing the HCBS Residential Setting Screening Tool](#).

Note: The face-to-face interview must be verified by a progress note entry in the clinical documentation. Signed attestation forms will no longer constitute proof of a face-to-face interview.

AMHH Clinical Eligibility Review Process

The AMHH provider agency electronically submits the AMHH application packet to the DMHA State Evaluation Team (SET) through the DARMHA system for the State's independent review and assessment of the applicant's clinical eligibility for the AMHH service. On receipt of the application, the SET completes the following to determine if the applicant meets clinical eligibility:

1. Reviews the AMHH member application packet for completeness. The following information is required for an AMHH application submission via DARMHA:
 - Applicant information
 - Waiver type
 - Current living situation
 - Description of the living situation
 - Justification of need for program
 - If application for renewal – assessment of progress toward meeting treatment goals during existing AMHH eligibility period
 - Information for the primary contact person for the applicant at the CMHC

- If applicable, applicant’s legal guardian
- Strengths
- Needs
- Services
- Attestations

Note: If the DMHA SET pends an application and it is not resubmitted within 7 calendar days from the date it was pended, the application may be denied.

1. Verifies that the applicant meets all target group criteria and needs-based AMHH eligibility criteria (see [Section 5: AMHH Program Member Eligibility](#) for more information about eligibility criteria).
2. Reviews the proposed Individualized Integrated Care Plan (IICP) to ensure that the plan meets the following criteria and supports the need for AMHH services:
 - Goals must be person-centered and address the applicant’s issues, to promote stability and continued community integration.
 - Objectives must be habilitative in nature, address the applicant’s needs, and identify the steps needed to accomplish the applicant’s goals (reflected in requested services).
 - Any other service that will be used to address mental and physical health needs is also listed as a strategy, as is the purpose of the service.
 - Services being requested should describe how the applicant will attain specified goals and objectives from IICP as well as any other services that may be accessed by the applicant to meet the identified goal/objective.
 - Attestations were signed and dated within 60 days from date of application submission.

AMHH Application

The first page of the AMHH application is for general applicant information and the second page is the Individualized Integrated Care Plan (IICP) Form. For instructions on completing this application and checking application status and history, see [Appendix C: AMHH Application Screen Shots](#).

Reviewing and Submitting the Application

After completing the AMHH member application (including but not limited to the clinical evaluation, ANSA, electronic application, and proposed IICP), the provider agency staff must review the application in its entirety to ensure complete and accurate information has been included. Special attention must be paid to the following areas:

- Ensure that each data element in the applicant data section that is automatically populated from DARMHA has a green check mark beside it. A red “X” by any of the elements indicates that the applicant does not meet the criteria and does not meet the eligibility requirements for the AMHH program. Applications submitted with any red “X” will be denied by the DMHA SET.
- Be sure that all narrative boxes are complete, with sufficient required information.
- Be sure that all required attestations have been checked and physical signatures obtained before submitting the application. A copy of the signed attestations must be maintained in the AMHH member’s clinical record.

The completed, reviewed application is submitted by clicking **Submit** at the bottom of the *IICP Form* page. If any outstanding items need to be addressed, a warning message pops up, alerting the staff completing the application that additional items need correction before submission.

*Note: If an AMHH application is incomplete, unclear, or has conflicting information, the SET may pend the application and require additional information or documentation from the provider agency. **The provider agency has 7 calendar days from date the application was pended to submit the required information in DARMHA. If the provider agency does not submit the required information or documentation within 7 calendar days, the AMHH application is subject to denial.***

To ensure no conflict of interest in AMHH eligibility determinations in all cases, the DMHA SET retains the authority to determine an applicant's eligibility for AMHH services and to authorize the use of the AMHH services documented on the approved IICP. For more information about the SET review of the AMHH application, eligibility determination, and services authorization, see [Section 11: AMHH Eligibility Determination, Service Approval, and Utilization](#).

Section 11: AMHH Service Eligibility and Authorizations

Under the direction and supervision of the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA), and FSSA Office of Medicaid Policy and Planning (OMPP), the State Evaluation Team (SET) is exclusively responsible for determining Adult Mental Health Habilitation (AMHH) eligibility and approving AMHH services on the proposed Individualized Integrated Care Plan (IICP). This section describes the SET processes for determining AMHH eligibility and approving AMHH services.

The State Evaluation Team (SET)

The SET assesses all AMHH applications for program and services eligibility. The team is responsible for determining the following:

- Eligibility of an applicant for enrollment and reenrollment in the AMHH program
- Appropriateness of proposed IICP and requested services in meeting the applicant's needs
- Clinical authorization of approved AMHH services

SET Assessment and Determination of Member Eligibility

If an AMHH application is incomplete, unclear, or has conflicting information, the SET may pend the application and require additional information or documentation from the provider agency. The provider agency has 7 calendar days from date the application was pended to submit the required information in the Data Assessment Registry Mental Health and Addiction (DARMHA). If the provider agency does not submit the required information or documentation within 7 calendar days, the AMHH application is subject to denial.

Following evaluation and review of the application, the SET makes one of three potential AMHH eligibility determinations:

- Approves AMHH program eligibility with full approval of services
- Denies eligibility for AMHH program and/or all requested services
- Approves AMHH program eligibility with partial approval of services

Note: AMHH services are requested individually, based on the member's identified needs documented on the proposed IICP. In some cases, certain requested services on a single IICP may be approved or denied by the SET, based on the independent evaluation of the applicant's needs and the justification provided for the service requested.

Determining a Start Date for AMHH Eligibility

The start date for AMHH program and services eligibility is determined by the SET. For approved applicants whose Medicaid Rehabilitation Option (MRO) package ends within 60 days of the date of SET approval, the AMHH start date is the day following the end date of the current MRO service package. This approach ensures that there is no lapse in services for the member.

For approved applicants whose MRO package ends beyond 60 days from date of the SET approval, the start date is set at 15 calendar days from the date the SET approves the AMHH application.

Note: There may be circumstances in which an applicant and provider identify a need to initiate AMHH services sooner than the start date normally determined by the SET. These requests are considered on a case-by-case basis and the start date is assigned as needed.

For members already receiving AMHH services, the start date for the new AMHH service package is the day following the end date of the current AMHH service package. This approach ensures that there is no lapse in services for the member.

Communication of the SET Eligibility Determination

Approval or denial of AMHH eligibility or services is communicated to the referring provider agency and the applicant or authorized representative in the following manner:

- *Approval of AMHH program eligibility with full approval of services:* If an applicant is determined eligible for the AMHH program and for all services requested on the IICP, DXC sends an authorization notification to the referring AMHH provider and the applicant or authorized representative. This notification includes the following information:
 - Start and end dates for AMHH program eligibility and services
 - AMHH services approved by the SET, including the procedure code, modifiers, and number of units approved
- *Denial of AMHH program and/or services eligibility:* If an applicant is determined ineligible for the AMHH program, or the SET denies all the AMHH services requested on the proposed IICP, a denial notification is sent to both the applicant or authorized representative and the referring AMHH provider. This denial notification is generated by the SET and includes the following information:
 - Notification of the reason(s) the SET determined the applicant is not eligible for the AMHH program
 - Notification of the reason(s) the specific services requested on the proposed IICP are denied
 - Information regarding the applicant's fair hearing and appeals rights
- *Approval of AMHH program eligibility with partial approval of services:* If an applicant is determined eligible for the AMHH program, but one or more (though not all) of the services requested on the proposed IICP are denied, an authorization notification and a denial notification are sent to the referring AMHH provider and the applicant or authorized representative. DXC sends the authorization notification and includes the following information:
 - Start and end dates for AMHH program eligibility and services
 - AMHH services approved by the SET, including the procedure code, modifiers, and number of units approved

Figures 1 through 3 show a sample Adult Mental Health Habilitation (AMHH) denial notification packet. Figures 1A and 1B show the denial notification form. Figure 2 shows a sample *Appeal Form for AMHH Services*. Figure 3 outlines an applicant's appeal rights.

Figure 1A – Sample Adult Mental Health Habilitation (AMHH) Denial Notification
(page 1 of 2)

FSSA/Indiana Division of Mental Health and Addiction

Date: MM/DD/YYYY

Indiana Government Center South
402 W. Washington Street, W353
Indianapolis, Indiana 46204
Office: 317-232-7800
Secure Fax: 317-233-1986



Indiana Medicaid Adult Mental Health Habilitation (AMHH) Services **DENIAL Notification**

Member Information	Provider Information
Member Name	Provider
Member Address	Provider Address
City, State, ZIP	City, State, ZIP
RID:	Submitted by: (DMHA SET staff)

The Division of Mental Health and Addiction (DMHA) has received your application for the Adult Mental Health Habilitation (AMHH) Services Program. You are receiving this notice because your application has been denied. This notice explains why your application has been determined as not meeting the eligibility criteria for the AMHH program and what your appeal rights are if you do not agree with the determination. **Please contact the provider who assisted in completing and submitting your application to discuss options and next steps.**

DARMHA ID:

Application Submit Date:

IICP Number:

IMPORTANT NOTICE: This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals.

APPLICATION TYPE:☐ Initial☐ Modification☐ Renewal**AMHH PROGRAM ELIGIBILITY:**☐ Yes☐ No

The AMHH Program Eligibility, 405 IAC 5-21.6-4, is denied due to the following reason(s):

☐ Does NOT meet one or more of the eligibility criteria:

- Age 35 or over
- AMHH eligible primary mental health diagnosis
- Medicaid enrolled
- Reside in a home or community based setting

☐ No recommendation for intensive community based care: Adult Needs and Strengths Assessment (ANSA) Level of Need (LON) is less than 4 and/or ANSA was completed more than 60 days prior to application submission

☐ Does NOT meet one or more of the needs based criteria:

- Demonstrated need for significant assistance in major life domains related to their mental illness
- Demonstrated significant need related to behavioral health
- Demonstrated significant impairment in self-management of mental illness, or demonstrated significant need for assistance with mental health management
- Demonstrated lack of sufficient natural supports to assist with mental illness management
- Not a danger to self or others

Figure 1B – Sample Adult Mental Health Habilitation (AMHH) Denial Notification
(page 2 of 2)

You are receiving this letter because of a **DENIAL** for one or more of the services in your proposed IICP under

Denial Date	Procedure Code	AMHH Service Denied	Reason(s) for Denial
MM/DD/YYYY	Service Procedure Code	Service Title	Reasons for denial
MM/DD/YYYY	Service Procedure Code	Service Title	Reasons for denial

(Repeated as needed for each requested service that is denied.)

1915(i) Adult Mental Health Habilitation program. The following service(s) have been **DENIED**:

The applicant and Selected Provider will review the Denial Form along with the letter explaining the action. If the service is still requested, the IICP must be reconfigured to provide supporting documentation and re-submitted for review.

Figure 2 – Appeal Form for AMHH Services

Appeal Form for Indiana Medicaid Adult Mental Health Habilitation Services			
Indiana Medicaid Adult Mental Health Habilitation Services Denial Notification			
Member Information			Provider Information
Member Name Member Address City, State, ZIP RID:			Provider Provider Address City, State, ZIP Submitted by: <i>(DMHA SET staff)</i>
Denial Date	Procedure Code	AMHH Service Denied	Reason(s) for Denial
MM/DD/YYYY	Service Procedure Code	Service Title	Reasons for denial
MM/DD/YYYY	Service Procedure Code	Service Title	Reasons for denial

(Repeated as needed for each requested service that is denied.)

If you wish to appeal this decision, please read the enclosed Appeal Rights as an Applicant for Adult Mental Health Habilitation Benefits. Sign and date below and return this completed form to begin the appeal process:

Mail to: Indiana Family and Social Services Administration
Office of Hearings and Appeals, MS 04
402 W Washington St, Room E034
Indianapolis, IN 46204

Fax: 317/232-4412 (Attn: Office of Hearings and Appeals)

I wish to appeal the above decision, for the following reasons:

Signature of Applicant/Guardian: _____ **Date:** _____

Relationship to Applicant: _____

Figure 3 – AMHH Applicant's Appeal Rights

Appeal Rights as an Applicant for Adult Mental Health Habilitation (AMHH)

If you have questions or disagree with the indicated decision, you should discuss this matter with your selected provider.

Right to Appeal and Have a Fair Hearing:

The Denial Notification provides an explanation of the decision made on your application for services or changes in your services. If you disagree with the decision, you have the right to appeal by submitting a request for a fair hearing. If you are currently receiving AMHH Services and your renewal application has been denied, your AMHH Services will continue if your appeal is received within the required time frame described below under "How to Request an Appeal" unless you request to end services.

Can I continue to get benefits when my appeal is pending?

- 1) New services cannot be started but you may keep your current benefits until an Administrative Law Judge (ALJ) issues a decision after an evidentiary hearing. In order to maintain your current benefits, you must file your appeal:
 - a) Within 10 calendar days of the date of the Notice; or
 - b) Before the date that the agency's decision goes into effect, whichever is later.
- 2) Any benefits you receive while your appeal is being decided may have to be paid back if the ALJ determines that the original decision is correct. However, you will only be responsible for paying back benefits provided to you on appeal after the authorization period.

How to Request an Appeal:

- 1) If you wish to appeal this decision, the appeal request must be received by close of business not later than:
 - a) 33 calendar days following the effective date of the action being appealed; or
 - b) 33 calendar days from the date of the notice of agency action, whichever is later.
- 2) To file an appeal, please sign, date and return the enclosed *Appeal Form for Indiana Medicaid Adult Mental Health Habilitation Services*:

Mail to: Indiana Family and Social Services Administration
Office of Hearings and Appeals, MS 04
402 W Washington St, Room E034
Indianapolis, IN 46204

Fax: 317/232-4412 (Attn: Office of Hearings and Appeals)
- 3) If you send a letter rather than this Denial Notification, be sure that the letter contains your full name, address and telephone number where you can be reached. Please attach a copy of this decision to the letter and state the name of the action you are appealing. If you are unable to sign, date, and return this form to the above mentioned address, you may have someone assist you in requesting the appeal. A telephone request for an appeal cannot be accepted.
- 4) You will be notified in writing by the Indiana Family and Social Services Administration, Office of Hearings and Appeals of the date, time and location for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Selected Provider.
- 5) You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative, or other spokesperson. At the hearing, you will have full opportunity to:
 - a) Call witnesses;
 - b) Establish all pertinent facts and circumstances;
 - c) Advance any arguments without interference and question; or
 - d) Refute any testimony or evidence presented.

The SET sends the denial notification to the AMHH provider and the applicant or authorized representative. The denial notification includes the following information:

- Notification of the reasons the specific services requested on the proposed IICP are denied
- A list of requested services that are approved by the SET
- Information regarding the applicant's fair hearing and appeals rights

The referring AMHH provider agency is responsible for alerting the applicant or member of the SET's eligibility determination and, in the event of a denial notification, assisting the member in understanding the reasons for the denial and pursuing the fair hearing and appeals process, as applicable.

Providers may access information regarding the status of an AMHH eligibility determination and approval of AMHH services via DARMHA, as well as authorization of AMHH service units, via the IHCP [Provider Healthcare Portal](#), accessible from the home page at in.gov/medicaid/providers. See the [Provider Healthcare Portal](#) module for information about registering for and using the IHCP Portal.

[Appendix E: AMHH Application Status Codes](#) explains the status codes that are viewable in the "Application Status" pull-down menu of the AMHH application in the DARMHA. The status code is updated whenever a new action is taken on an AMHH application. Providers can use this code to track where an application is in the review and approval process.

AMHH Services – Eligibility Period

The AMHH services eligibility period is 1 year (360 days) from the start date documented on the AMHH eligibility authorization notification, or as determined by the SET. AMHH service delivery may not begin until the service approval from the SET is authorized, and DXC assigns the member the AMHH services package. AMHH provider agencies will not receive reimbursement for any AMHH services provided without SET approval and authorization, or for services provided outside the AMHH eligibility period, as documented on the authorization notification. The provider agency is required to:

- Continually monitor the member's progress and benefit from AMHH services, and notify the DMHA if there is any change in status that impacts the member's eligibility for AMHH services
- When the needs of the member change, requiring new or different AMHH services, the provider must update the IICP and submit it to the SET for review and approval of the requested AMHH services (See [Section 13: AMHH Eligibility Period and Renewal of Eligibility](#) for information regarding requests for additional AMHH services.)
- Track the end date of the member's AMHH program and services eligibility, and submit an AMHH renewal application at least 30 days (but no more than 60 days) before the end date of the existing AMHH eligibility period – see [Section 12: Renewal of AMHH Program Member Eligibility](#) in this module for additional information.

Note: The AMHH provider agency is responsible to ensure that the AMHH services renewal application is submitted to the SET at least 30 days before the expiration date of the member's current AMHH eligibility period. In addition, a new ANSA must be completed and submitted within 60 days of creating the AMHH renewal application.

Approval for AMHH Units of Services

The SET authorizes AMHH services for an AMHH-eligible member, based on review and acceptance of the proposed IICP submitted in DARMHA. The AMHH services approval provides a maximum number of service units for each AMHH service approved. AMHH providers must coordinate service delivery to ensure that the AMHH service units approved by the SET are managed in a way to ensure continued service delivery throughout the AMHH eligibility period, based on the member's needs. **No additional units of service for an approved service can be requested during the authorized eligibility period.** However, if the needs of the member change, an additional AMHH service (one not already authorized) may be requested. See [Section 13: AMHH Eligibility Period and Renewal of Eligibility](#) for information about requesting additional AMHH services.

Interruption of AMHH Services

When AMHH services are interrupted because the member is leaving the community to enter an institutional setting (for example, incarceration, hospitalization, and so on), AMHH services are not reimbursable or billable during the service interruption. The AMHH eligibility and authorized service units remain available to the member, in the originally authorized AMHH eligibility period, for immediate access when the member returns to the community from the institutional setting and chooses to restart AMHH services.

If, however, the member does not return to the community during the AMHH eligibility period, the member must reapply for AMHH services before or upon reintegrating into the community, with the assistance of a DMHA-approved AMHH provider agency. To retain continuity of care, AMHH program eligibility and service requests may be applied for while an individual is in an institutional setting and preparing for discharge back into the community, so long as the request includes a specific discharge date within 90 days of submitting the application. If approved, AMHH services are not reimbursable until the applicant has returned to a community-based setting.

Termination of AMHH Services

If AMHH services must be terminated before the end of the AMHH eligibility period because the member has asked to terminate AMHH services or no longer meets AMHH criteria, the provider agency must help link the member to services that may be able to meet the individual's needs. (For information about transitioning to MRO services, see [Section 14: Transitions during AMHH Eligibility Period.](#))

If the provider agency's efforts to facilitate a transition in services for the member are not successful, the provider agency must document in the clinical record the attempts made to coordinate transition to other services.

Section 12: Renewal of AMHH Program Member Eligibility

The member's Adult Mental Health Habilitation (AMHH) program and services eligibility period expires 1 year (360 days) from the date of the AMHH start date, or as otherwise determined by the State Evaluation Team (SET). To continue AMHH services and prevent a lapse in service delivery for an eligible member, the AMHH member, in conjunction with the AMHH provider agency, must reapply for AMHH program eligibility at least 30 days (and no more than 60 days) before the eligibility expiration date.

The AMHH renewal application and evaluation process is the same as the initial AMHH application process outlined in *Sections 6, 7, and 10* of this module, including the following:

- Completing a face-to-face holistic clinical and biopsychosocial assessment – a qualified Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA)-approved AMHH service provider must evaluate the member's strengths, needs, and functional impairments
- Completing the clinical assessment and Adult Needs and Strengths Assessment (ANSA) tool to assess whether the member meets the level of need recommendation and needs-based criteria for AMHH services. The assessment and the ANSA must be completed within 60 days of creating the AMHH renewal application.
- Updating the Individualized Integrated Care Plan (IICP), crisis plan, and attestations
- Evaluating the member's progress toward meeting established habilitative treatment goals
- Determining if and how the member is receiving benefits from AMHH services
- Submitting the renewal application in the Data Assessment Registry Mental Health and Addiction (DARMHA)

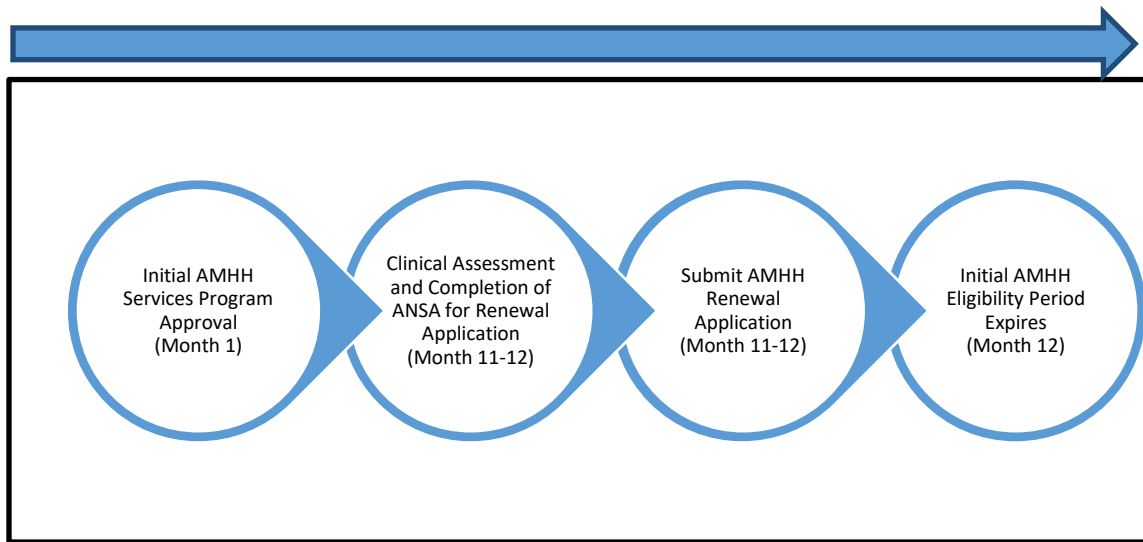
Note: The member, with assistance from the AMHH service provider, must reapply for AMHH program eligibility at least 30 days (but not more than 60 days) before the eligibility expiration date to prevent an interruption in service delivery. See Figure 4 for a timeline for renewing AMHH services.

If an AMHH application is incomplete, unclear, or has conflicting information, the SET may pend the application and require additional information or documentation from the provider agency. The provider agency has 7 calendar days from the date the application was pended to submit the required information in DARMHA. If the provider agency does not submit the required information or documentation within 7 calendar days, the AMHH application is subject to denial.

Approval or denial of continued AMHH eligibility and services is communicated to the referring provider agency and the applicant or authorized representative, as described in [Section 11: AMHH Service Eligibility Authorizations](#).

Figure 4 illustrates the AMHH services renewal application timeline.

Figure 4 – AMHH Program – Renewal Application Timeline



Section 13: AMHH Eligibility Period and Renewal of Eligibility

If an Adult Mental Health Habilitation (AMHH) member's needs change or additional AMHH services are indicated to meet the member's needs, the provider agency may request approval of additional AMHH services not already approved by the State Evaluation Team (SET) in the member's current AMHH eligibility period. Additional AMHH service units are not authorized for services already approved within the member's AMHH eligibility period.

A request for additional AMHH services is initiated when the AMHH provider agency submits a request to the SET, as follows:

- The provider agency completes an updated Individualized Integrated Care Plan (IICP) (with "AMHH Modification" indicated on the application form) and submits it to the SET via the Data Assessment Registry Mental Health and Addiction (DARMHA).
- After receiving the AMHH Modification Application, the SET reviews the modified IICP and supporting documentation, as described in [Section 11: AMHH Service Eligibility Authorizations](#) in this module.
- After evaluation and review of the modified IICP, the SET makes a determination regarding the request to add new AMHH services.
- Approval or denial of requested additional AMHH services is communicated to the referring provider agency and the applicant or authorized representative in the following manner:
 - *Approval of additional AMHH services:* If the SET approves the requested additional AMHH services, an authorization notification is sent to the referring AMHH provider and the member or authorized representative, notifying them of the approval. DXC sends an authorization notification that includes the following information:
 - The AMHH services approved, including the procedure code, modifiers, and number of units approved
 - Start and end dates for the approved AMHH services. When additional services are approved, the start date is the date the SET approves the requested service. The end date is the same as the member's current AMHH eligibility period end date.
 - *Denial of additional AMHH services:* If the SET denies one or more requested additional AMHH services on the modified IICP, the SET sends a denial notification to the member and referring AMHH provider, notifying them that the AMHH services requested were denied. The denial notification includes the reasons for denial and information regarding the applicant's fair hearing and appeals rights.

Note: The AMHH provider agency is responsible for alerting the applicant or member of the SET's eligibility determination and, in the event of a denial notification, the provider helps the member understand or pursue the fair hearing and appeals process, as applicable.

The additional authorized AMHH services are subject to applicable AMHH service unit limitations for those services and have an expiration date that matches the member's existing AMHH eligibility period expiration date. Information regarding assignment of additional AMHH service packages may be accessed by providers on the IHCP [Provider Healthcare Portal](#).

Service delivery for the requested additional AMHH services may not begin until approval and authorization from the SET is complete and the services are assigned by DXC. AMHH provider agencies do not receive reimbursement for any AMHH services provided without SET approval and authorization, or for services provided outside the AMHH eligibility period documented on the authorization notification. Figure 5 shows a Request for Additional AMHH Services.

Figure 5 – Request for Additional AMHH Services

An AMHH member receives an eligibility approval determination for AMHH services on January 1 (for 360 days). In June, the applicant begins to decompensate due to increased alcohol consumption and poor judgment in time utilization during the day when the member's caregiver (roommate) is at work. Additional services are indicated to support the AMHH member in the community. The additional services are requested by the AMHH provider and are approved by the SET on June 20. The newly approved services have the same expiration date as the AMHH eligibility period and services authorized in January.			
AMHH Service Requested	# Units Authorized	Authorization Period (360 days)	Reason for Denial
The initial AMHH eligibility authorization is granted on January 1 with the following services authorized on the IICP:			
HCB Habilitation and Support	2,920	Jan 1 – Dec 26	
Therapy and Behavioral Support Services	96 (individual), 126 (group)	Jan 1 – Dec 26	
Medication Training and Support	728	Jan 1 – Dec 26	
Care Coordination	800	Jan 1 – Dec 26	
The AMHH applicant has increased symptoms and decompensated functioning. The provider requests additional services to support the member so he or she may continue to live safely in the community. Authorization of additional AMHH services is granted on June 20:			
Adult Day Services	2 half-day units/day, 5 days/week	June 20 – Dec 26	
Addiction Counseling	64	June 20 – Dec 26	
Therapy and Behavioral Support Services	0	Request Denied	*Service already authorized within the same eligibility period
* AMHH services are authorized with a fixed number of units per time period, based on the individual service. No additional units will be authorized for a service after the initial authorization within the same eligibility period. It is the responsibility of the provider to manage the units authorized to ensure the member's needs are met within the AMHH eligibility period.			

Section 14: Transitions during AMHH Eligibility Period

The Adult Mental Health Habilitation (AMHH) provider agency must respect the member's right to freedom of choice regarding program participation and choice of AMHH service providers. The AMHH provider agency must provide the greatest assistance possible to facilitate a transition or change in AMHH service providers at the member's request. It is the responsibility of the AMHH provider agency to coordinate any transition in services for an AMHH member, such as:

- Transition between AMHH provider staff members within the same AMHH provider agency
- Transition between AMHH provider agencies
- Transition from AMHH services to other programs, such as Medicaid Rehabilitation Option (MRO), as applicable

Transition between AMHH Service Provider Staff within an Agency

AMHH members have the right to choose who provides their services within an agency. Members may request that specific agency staff provide AMHH services, so long as those staff members are appropriately qualified and trained to provide the service. All requests must be honored, whenever possible, to ensure member choice.

Transition between AMHH Provider Agencies

To assist with a transition between provider agencies, the current AMHH provider agency must engage in the following to maintain continuity of care for the member:

- Provide the member with a randomized listing of AMHH provider agencies in the member's county of residence and contiguous counties, so the member is able to make an informed choice in selecting a new AMHH provider agency
- Assist in linking the member with the new AMHH provider agency, which includes the transfer of clinical information to coordinate care (with a signed consent if the transfer is between provider agencies and not an internal transfer within the same agency). The information transferred may include the member's last assessment, current Individualized Integrated Care Plan (IICP) and progress notes, crisis plan, and so on, that will assist the new provider agency in continuing care with minimum disruption in service delivery.
- Communicate with the new provider agency regarding service unit utilization during the existing AMHH eligibility period

Note: Authorization for AMHH services belongs to and follows the AMHH member, not the provider agency. The number of approved AMHH service units does not change due to a transfer between provider agencies. If additional AMHH services are indicated to meet the member's needs (other than the ones originally approved by the State Evaluation Team [SET]), the new provider agency must follow the process for requesting additional services. See [Section 13: AMHH Eligibility Period and Renewal of Eligibility](#).

Voluntary Transition from AMHH Services to MRO Services

If AMHH program members choose, they may request to be transitioned to (or back to) a Medicaid Rehabilitation Option (MRO) service package. To assist in a transition to MRO, the AMHH provider agency must engage in the following to maintain continuity of care for the member:

- Complete and submit an Adult Needs and Strengths Assessment (ANSA) reassessment within 60 days of the requested date of transition to MRO. A current (within 60 days) ANSA is necessary for determining MRO eligibility and service package assignment.
- Complete the Transition to MRO wizard under the *IICP Form* tab on the currently approved AMHH application in the Data Assessment Registry Mental Health and Addiction (DARMHA). Submit an email to the SET (AMHHServices@fssa.in.gov) informing them of the need to transfer the AMHH member back to MRO. The requested date of transition must be no earlier than the date the transition request is submitted and no later than the end of the current AMHH eligibility period. See [Section 10: AMHH Service Eligibility – Initial AMHH Application](#) for instructions.

The SET evaluates the transition request and, when approved, DARMHA sends an AMHH end date to DXC. The following day, DARMHA auto-generates an MRO eligibility request file and sends that to DXC for MRO eligibility determination. If the MRO eligibility criteria and Medicaid status are met (current level of need, active Medicaid ID, and diagnosis), DXC generates and authorizes an MRO service package with an effective date the day after the AMHH end date. If the date on the most recent ANSA is more than 60 days before the AMHH package end date provided by DARMHA, DXC does not generate an MRO service package because the date of assessment does not qualify, which may result in a lapse in service authorization for the member. The provider agency will not receive authorization or payment for services delivered between the end of the AMHH service authorization and the beginning of an MRO service package.

Providers may not submit claims for MRO services and AMHH services simultaneously. Services under these two programs are mutually exclusive. It is the provider's responsibility to verify eligibility prior to rendering services to a client. Providers may bill only AMHH services during an AMHH program eligibility period even if an MRO service package is also noted as active. After the AMHH service eligibility and service authorization is end-dated, the member can utilize MRO services if there is an authorized service package in place.

Default Transition from AMHH Services to MRO Services

If the current AMHH eligibility period ends without an approved AMHH renewal request and the most recent ANSA is less than 60 days old, an MRO eligibility request file auto-generates from DARMHA and is sent to DXC for MRO eligibility determination. If the MRO eligibility criteria and Medicaid status requirements are met (including the level of need, active Medicaid ID, and diagnosis), DXC generates and authorizes an MRO service package with an effective date the day after the AMHH end date (which will become the AMHH eligibility end date). If the ANSA is more than 60 days old (from AMHH eligibility end date), the provider must complete a new ANSA and submit it to DARMHA to trigger the MRO eligibility request file being sent to DXC for MRO eligibility determination. If neither AMHH nor MRO eligibility is established, the result is a lapse in the member's program eligibility and service authorization. The provider agency will not receive payment for services delivered outside an authorized eligibility period for either program.

*Note: **MRO eligibility determination is contingent on current assessments.** Providers are strongly encouraged to complete an ANSA reassessment within the required time frame (no more than 60 days before the end date of the current service package eligibility end date) to support ongoing or re-establish program eligibility. For additional information regarding MRO eligibility and service packages, see the [Medicaid Rehabilitation Option Services](#) module.*

Section 15: Clinical and Administrative Documentation

The Adult Mental Health Habilitation (AMHH) provider agency must comply with documentation requirements, as defined by the [Centers for Medicare & Medicaid Services \(CMS\)](#), the Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) and the FSSA Division of Mental Health and Addiction (DMHA), this AMHH provider module, and *Indiana Administrative Code 405 IAC 1-5*. All clinical record documentation must contain information that reflects the AMHH services provided to the member. The documentation required to support billing for AMHH services must:

- Focus on the member
- Emphasize the member's strengths
- Reflect the member's progress toward the habilitation goals reflected in the Individualized Integrated Care Plan (IICP)
- Be present in the member's medical record for every member encounter for which billing is submitted for reimbursement
- Be written and signed by the provider rendering services (and cosigned if applicable)
- Follow all documentation requirements outlined in this module

For complete service definitions, provider qualifications, program standards, and exclusions, see AMHH services outlined in this module (*Sections 17-25*).

Service Location Specifications

It is essential that the location where an AMHH service is provided is clearly documented in the member's clinical record. AMHH is a 1915(i) Home and Community-Based Services (HCBS) program, AMHH services must be provided in home and community-based settings to be eligible for reimbursement. For more information, see [Section 4: AMHH Member Home and Community-Based Settings Requirements](#) and *sections 17-25* of this module, and the [FSSA Home and Community-Based Services Final Rule](#) website at in.gov/fssa.

General Documentation Requirements

The AMHH provider agency must comply with the standards for documentation required for each AMHH service provided. Although each AMHH service may have its own unique documentation requirements in addition to the general requirements listed here, this section provides information about general documentation requirements that apply to all AMHH services. Documentation standards specific to each AMHH service are detailed, along with the service definition, scope, limitations, and exclusions, in subsequent sections of this module (see *sections 17-25*). Providers are responsible for understanding and adhering to the requirements and limitations for each service they are qualified and authorized to provide. Questions about a service and its requirements may be directed to the State Evaluation Team (SET), which is responsible for completing AMHH quality assurance activities in support of the CMS and FSSA/OMPP requirements for the delivery of AMHH services.

The following applies to each AMHH service that is claimed for reimbursement:

- All AMHH service and eligibility documentation is subject to review by the CMS and the State, or their designees.
- The provider is subject to denial of payment or recoupment for paid claims if the provider does not have adequate documentation to support the AMHH service billed.

The following documentation requirements apply for each AMHH service encounter:

- Type or title of service provided
- Name and qualifications of the staff member providing the service

*Note: AMHH progress notes **must** include the staff qualifications (such as OBHP, QBHP, LCSW, and so on). Degree indication is optional.*

- Location or setting where the service was provided
- Description of the focus on the member and of the session or service delivered to or on behalf of the member
- Symptoms, issues, and/or goals addressed during the session
- Duration of the service (actual time spent with the member or completing the activity)
- Start and end time of the service
- Member's Individualized Integrated Care Plan (IICP) goals addressed during the session
- Progress made toward the habilitation goals
- Date of service rendered (including month, day, and year)
- Strengths of the client

Note: Individualized goals are habilitative in nature. Progress may be described as sustained maintenance or acquiring of skills or functioning, allowing the individual to live in the community in the least-restrictive environment possible.

The content of the documentation must support the amount of time billed. In addition to the requirements listed in this section, additional requirements for specific service types are reflected in the following subsections.

Services Provided in a Group Setting

For members participating in AMHH services provided in a group setting (for example, Adult Day Services can also apply to Home and Community-Based Habilitation and Support, Therapy and Behavioral Support Services, Addiction Counseling, and Medication Training and Support), documentation provided for each encounter must include:

- All items described under General Documentation Requirements
- Focus or topic of the group or session and how it applied to the specific member's goals
- Member's level of engagement and participation in the group session. Simply noting whether the member was present in the group does not constitute adequate documentation.

Services Provided without the Member

For services provided without the member (neither face-to-face nor via telephone) (can apply to Home and Community-Based Habilitation and Support, Therapy and Behavioral Support Services, Addiction Counseling, Care Coordination, and Medication Training and Support), documentation provided for each encounter must include:

- All items described under General Documentation Requirements
- The persons who attended the session and their relationship with the member
- How the session addresses the member's goals
- How the service benefits the member

Service-Specific Documentation Requirements

The following services have additional documentation requirements, as described. For all other AMHH services, only the general documentation requirements apply.

Adult Day Services

Adult Day Services is a time-limited, nonresidential service provided in a clinically supervised setting for members who require structured habilitative services to maintain their outpatient status. Adult Day Services are curriculum-based and designed to alleviate emotional or behavior problems, with the goal of transitioning the member to a less-restrictive level of care, reintegrating the member into the community, and increasing the member's social connectedness beyond a clinical setting and/or employment. For a complete definition of Adult Day Services, see [Section 17: Adult Day Services](#).

Documentation requirements include, at minimum, weekly reviews with details of daily activities and progress updates that include details of services provided each day in accordance with the following:

- All items under General Documentation Requirements
- All requirements noted in Services Provided in a Group Setting
- Member's goals and a transitional plan to reintegrate the member into the community

Note: Providers may opt to use daily documentation versus a weekly review as long as the agency is consistent about which method is used. Daily reviews require all the same documentation elements weekly reviews do.

Respite Care Services

Respite Care services are services provided to members who are unable to care for themselves. These services are furnished on a short-term basis because of a nonprofessional caregiver's absence or need for relief. For a complete definition of Respite Care services, see [Section 19: Respite Care](#). Documentation requirements include:

- All items under General Documentation Requirements
- The primary location where services are rendered and the reason for the respite services
- Nature of the services delivered to the member
- Documentation of the activities the member engaged in during the respite and how the member responded

Section 16: Grievances and Complaints

Adult Mental Health Habilitation (AMHH) provider agencies must ensure that all AMHH members in the agency's care retain the following rights:

- To receive appropriate behavioral health services in accordance with standards of professional practice, appropriate to the member's needs and designed to afford the individual a reasonable opportunity to maintain or improve his or her condition
- To participate in the planning of the Individualized Integrated Care Plan (IICP), including receiving assistance in understanding and being informed of the nature of the treatment program proposed, the known effects of receiving and not receiving such treatment, and alternative treatments, if any
- To refuse to submit to treatment, including medication or services, as an adult voluntary patient
- To be treated with consideration, dignity, and respect, free from mental, verbal, and physical abuse or neglect
- To have freedom of choice regarding which Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA)-approved AMHH provider agency (or agencies) delivers AMHH services, and the freedom to change AMHH provider agencies at any time during the AMHH services eligibility period
- To have the right to choose to receive services in a non-disability-specific setting selected by the member/family
- To be sure of confidentiality and protection of personal identifying and treatment-related information, as provided under the *Health Insurance Portability and Accountability Act* (HIPAA)

Each DMHA-approved AMHH provider agency is required to ensure that each AMHH participant receives a written statement of rights. In addition to listing the participant's rights, the statement must also include:

- The toll-free telephone numbers for the DMHA consumer service line (1-800-901-1133) and [Indiana Disability Rights](https://www.in.gov/dmha/indiana-disability-rights) (1-800-622-4845)
 - For individuals that are deaf, hard-of-hearing, or speech impaired, Relay Indiana can be contacted by dialing 711. For more information, call 1-877-446-8722 or email info@relayindiana.com.
- A place for participants to affirm that they received written and oral explanation of the rights.
 - The agency must retain a copy of this affirmation for each applicant/member in their medical record.

Grievance or Complaint-Reporting Policy

The objective of the grievance or complaint-reporting policy is to provide members with a formal process to ensure that the individual can voice concerns, complaints, and grievances regarding the AMHH program to the DMHA for review and resolution. Provider agencies are required to help members understand their rights and options regarding filing a grievance or complaint about AMHH services and service delivery to the DMHA. Provider agencies are required to follow the DMHA policy for grievances and complaints located at the [Office of Family & Consumer Affairs](https://www.in.gov/dmha/office-of-family-consumer-affairs) page at [in.gov/dmha](https://www.in.gov/dmha).

Section 17: Adult Day Services

Adult Mental Health Habilitation (AMHH) Adult Day Services consists of community-based group programs designed to meet the needs of adults with significant behavioral health impairments, as identified in members' Individualized Integrated Care Plans (IICPs). These comprehensive, nonresidential programs provide health, wellness, social, and therapeutic activities in a structured, supportive environment. The services provide supervision, support services, and personal care, as required by the member's IICP.

AMHH Adult Day Services may include:

- Care planning
- Behavioral health treatment
- Monitoring weight, blood glucose level, and blood pressure
- Medication administration
- Nutritional assessment and planning
- Individual or group exercise training
- Training in activities of daily living (ADLs)
- Skill reinforcement for established skills

Adult Day Services may also include other social activities, as indicated, to meet identified needs and goals established in the IICP.

Provider Qualifications

The staff that provides AMHH Adult Day Services must have the following qualifications:

- Licensed professional, except for licensed clinical addiction counselors
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

Medication administration provided as part of AMHH Adult Day Services must be delivered by a provider who meets one of the following qualifications:

- A licensed physician
- An authorized healthcare professional (AHCP)
- A registered nurse (RN)
- A licensed practical nurse (LPN)
- A medical assistant (MA) who has graduated from a 2-year clinical program

Nutritional assessment and planning services provided as part of AMHH Adult Day Services activity must be provided by a certified dietician, as defined in *Indiana Code IC 25-14.5-1-4*.

See *Agency Staff Requirements* in [Section 3: AMHH Agency Staff Requirements](#) for additional information about staff member qualifications.

Program Standards

Program standards for AMHH Adult Day Services include the following:

- The services require face-to-face contact with the member, and the member must be the focus of the services delivered.
- The member's goals must be designed to facilitate community integration and use natural supports.
- Therapeutic services include clinical therapies, psychoeducational groups, and habilitative activities.
- Documentation must support how the services benefit the member, including when the services are provided in a group setting.
- Medication administration must be provided within the scope of practice of the provider staff member, as defined by federal and State law. See the [Indiana Professional Licensing Agency](#) for additional information.
- Nutritional assessment and planning services must be delivered by a certified dietician and provided within the scope of practice, as defined in State and federal law. See the Indiana Professional Licensing Agency for additional information.
- Each day of service must be appropriately documented in the member's clinical record.
- At a minimum, a weekly review and update of the member's progress toward habilitative goals must occur and be documented in the member's clinical record. Providers may opt to use daily documentation versus a weekly review summary, as long as the agency is consistent about which method is used. Daily reviews require all the same documentation weekly reviews do.

Requirement for Clinical Oversight

Program standards for AMHH Adult Day Services require that a licensed physician provide clinical oversight of the program. This licensed physician must be on-site at least once a week and available to program staff when not on-site. This requirement is in addition to the general requirement that approved agency staff (QBHP, OBHP, and so on) must be supervised by a licensed professional.

Exclusions

General AMHH program exclusions are outlined in *Noncovered Services* in [Section 2: Adult Mental Health Habilitation \(AMHH\) Program Overview](#). The following exclusions apply and are nonreimbursable or noncovered for AMHH Adult Day Services:

- Formal educational or vocational services are considered nonreimbursable or noncovered.
- Adult Day Services are not eligible for reimbursement if provided in a residential setting, as defined by the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA).
- If services are provided simultaneously with other services, only one of the services provided is billable.

HCPCS Codes

Table 1 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Adult Day Services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 1 – HCPCS Codes for Adult Day Services

Code	Modifier	Code Description	Limitations
S5101	UB	Day care services, adult; per half day; adult mental health	Maximum is 1 day (2 units) (1 unit = 1/2 day), 5 days per week

Service Unit Description and Limitations

The basic unit of service for AMHH Adult Day Services is a half-day unit. A single half-day unit is defined as providing service for a minimum of 3 hours to a maximum of 5 hours per day.

- Two units are defined as the service provided for more than 5 hours to a maximum of 8 hours per day.
- A maximum of two half-day units per day is allowed, up to 5 days per week, with a maximum of 10 units in a 5-day period. A second half-day unit may be billed only when a previous entire half-day unit (5 hours, plus 60-minute break) has been provided to the member.

For additional guidance about calculating and billing service time for Adult Day Services, see [Section 26: AMHH Program Billing](#).

Section 18: Home and Community-Based Habilitation and Support

Adult Mental Health Habilitation (AMHH) Home and Community-Based Habilitation and Support services are individualized face-to-face services focused on the member's health, safety, and welfare. These services are intended to:

- Provide skills training to reinforce established skills (may include activities of daily living (ADLs))
- Help members manage, adapt, and retain skills necessary to support their ability to live successfully in the community-integrated settings most appropriate to their needs
- Help members manage their behavioral and medical health conditions

Services are provided in the member's home (living environment) or other community-based settings outside clinic or office environments.

Home and Community-Based Habilitation and Support services may be provided to:

- Members individually in individual or group settings
- Family members or other nonprofessional caregivers in individual or group settings, with or without the members present

An "individual setting" means that the activity is meant to benefit one client, even though the activity may include family members and nonprofessional caregivers, and the client may or may not be present during the activity. A "group setting" means the activity is meant to benefit more than one client, even though, again, the activity may include family members and professional caregivers of multiple clients, and the clients may or may not be present during the activity. The benefit to the client must be in accordance with each client's individual treatment goals.

Example 1: An AMHH client, "Juan," attends a family counseling session with his siblings and mother. Because the session is intended to benefit only Juan, it is considered an individual setting, even though multiple people are present.

Example 2: The families of several clients meet for an orientation session for an upcoming AMHH skills development group, which will be attended by several AMHH clients. Because the group includes and will benefit more than one client, the activity is considered a group setting.

Provider Qualifications

Provider staff of AMHH Home and Community-Based Habilitation and Support services must have one of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

For additional information on staff member qualifications, see [Section 3: AMHH Agency Staff Requirements](#).

Program Standards

Program standards for AMHH Home and Community-Based Habilitation and Support services include:

- The services require face-to-face contact. The contact may be with or without the member present, with or without family members and nonprofessional caregivers present, in an individual or group setting.
- The member is expected to show benefit from the services.
- Services must be goal-oriented and related to the Individualized Integrated Care Plan (IICP).
- When provided to family members or caregivers, services must be focused on the member and improve the ability of the parent, family member, or primary caregiver to provide care to or for the member.
- Activities include:
 - Implementation of the IICP
 - Assistance with personal care
 - Coordination and facilitation of medical and nonmedical services to meet healthcare needs
 - **When family members and nonprofessional caregivers are present:** Training and education to instruct parents or other family members identified in the IICP, or primary (nonprofessional) caregivers about the treatment regimens appropriate to the member
- Services may include, but are not limited to, the following:
 - Skills training in food planning and preparation, money management, and maintenance of the living environment
 - Medication-related education and training by nonmedical staff
 - Training in appropriate use of community-based activities, such as riding the bus, going to the library, and participating in natural support systems, such as faith-based or social activities in the community
 - Training in skills needed to locate and maintain a home, including:
 - Landlord and tenant negotiations
 - Budgeting to meet housing and housing-related expenses
 - Locating and interviewing prospective roommates
 - Renter's rights and responsibilities

Note: Activities allowed under Home and Community-Based Habilitation and Support services are intended to focus on the maintenance of basic skills for living in the community.

Activities allowed under Supported Community Engagement Services are intended to engage a member in meaningful community involvement through activities such as volunteerism or community service.

Exclusions

Exclusions to the general AMHH program are outlined in [Section 2: Adult Mental Health Habilitation \(AMHH\) Program Overview](#). The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Home and Community-Based Habilitation and Support services:

- Job coaching
- Academic tutoring
- Services provided to professional caregivers

- Skill-building activities not identified in the IICP
- Activities billed under AMHH Supported Community Engagement Services, such as skills training and support related to community engagements (for example, obtaining or maintaining a meaningful purpose or role in the community)

HCPCS Codes

Table 2 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Home and Community-Based Habilitation and Support services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 2 – HCPCS Codes for Home and Community-Based Habilitation and Support Services

Code	Modifiers	Code Description	Limitations
H2014	UB	Skills training and development, per 15 minutes; adult mental health habilitation	Maximum is 2 hours (8 units) (1 unit = 15 minutes), every day
H2014	UB HR	Skills training and development, per 15 minutes; adult mental health; family/couple with client present	Maximum is 2 hours (8 units) (1 unit = 15 minutes), every day
H2014	UB HS	Skills training and development, per 15 minutes; adult mental health habilitation; family/couple without client	Maximum is 2 hours (8 units) (1 unit = 15 minutes), every day
H2014	UB U1	Skills training and development, per 15 minutes; adult mental health habilitation; group setting	Maximum is 2 hours (8 units) (1 unit = 15 minutes), every day
H2014	UB U1 HR	Skills training and development, per 15 minutes; adult mental health habilitation; group setting; family/couple with client	Maximum is 2 hours (8 units) (1 unit = 15 minutes), every day
H2014	UB U1 HS	Skills training and development, per 15 minutes; adult mental health habilitation; group setting; family/couple without client	Maximum is 2 hours (8 units) (1 unit = 15 minutes), every day

Service Unit Description and Limitations

The basic unit of service for AMHH Home and Community-Based Habilitation and Support services is a 15-minute unit. Home and Community-Based Habilitation and Support services, including all subtypes (individual or group setting, with or without family/couple or nonprofessional caregivers, with and without member present), may be provided for up to a total of 2 hours or 8 units per day, each day, throughout the eligibility period. See [Section 26: AMHH Program Billing](#) for additional information.

Section 19: Respite Care

Adult Mental Health Habilitation (AMHH) Respite Care services are provided to members who are unable to care for themselves and who are living with nonprofessional caregivers. The service is provided on a short-term basis because of the nonprofessional caregiver's absence or need for relief. This service is intended to provide support, supervision, and services necessary to ensure members' health and safety if the member is not able to provide for themselves while the primary caregivers are unavailable for a short and defined period.

AMHH Respite Care services may be provided in any of the following locations:

- Member's home or place of residence
- Caregiver's home
- Nonprivate residential setting (such as a group home or adult foster care)

Provider Qualifications

Providers of AMHH Respite Care services, except for medication administration and medical support services provided as part of Respite Care, must have one of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

Medication administration and medical support services provided through the AMHH Respite Care service must be within the scope of practice, as defined by federal and State law, by an agency staff member who meets one of the following qualifications:

- A licensed physician
- A physician assistant
- A registered nurse
- A licensed practical nurse (LPN)

See [Section 3: AMHH Agency Staff Requirements](#) for additional information about qualifications for provider agency and staff members.

Program Standards

Program standards for AMHH Respite Care services include the following:

- The member must be living with a nonprofessional (unpaid) caregiver.
- The location where service is provided and the level of professional care are based on the needs of the member receiving the service, and may include regular monitoring of medications or behavioral symptoms, as identified in the Individualized Integrated Care Plan (IICP).
- Services must be provided in the least-restrictive environment available and ensure the health and welfare of the member.

- Services must not be used as substitutes for regular care to allow the member's caregiver to:
 - Attend school
 - Hold a job
 - Engage in employment- or employment search-related activities
- Medication administration and medical support services provided with respite care must be provided within the scope of practice, as defined by federal and State law.
- Services must be provided by a DMHA-approved provider.
- Respite care must not duplicate any other service being provided under the member's IICP.

Exclusions

General AMHH program exclusions are outlined in [Section 2: Adult Mental Health Habilitation \(AMHH\) Program Overview](#). The following specific exclusions apply and are nonreimbursable or noncovered as AMHH Respite Care services:

- Services provided to members living in Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA)-certified residential facilities
- Services provided to members living in supportive housing
- Services provided to members who receive in-home support from professional caregivers, rather than nonpaid caregivers
- Respite care provided by either of the following:
 - Any relative who is the primary caregiver of the member
 - Anyone living in the member's residence
- Services provided to members by family or friends (respite services must be provided by DMHA-approved providers)
- Any service that meets the definition of hospice services

HCPCS Codes

Table 3 shows the Healthcare Common Procedure Coding System codes for Respite Care services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 3 – HCPCS Codes for Respite Care Services

Code	Modifier	Code Description	Limitations
S5150	UB	Unskilled respite care, not hospice; per 15 minutes; adult mental health habilitation	Maximum is 75 hours (28 units) (1 unit = 15 minutes), per 24-hour period, up to 300 units per eligibility period
S5151	UB	Unskilled respite care, not hospice; per diem; adult mental health habilitation	Maximum is 28 days (28 units) (1 unit = 1 day), per eligibility period, no more than 14 consecutive days

Service Unit Description and Limitations

There are two basic units of service for AMHH Respite Care services: hourly or daily. The available number of units per AMHH eligibility period depends on whether the Respite Care service is provided hourly or daily:

- *Hourly Respite Care:* The basic unit is a 15-minute unit, which applies to services provided up to 7 hours, or 28 units, per day. Hourly Respite Care is available for a maximum of 75 hours (300 units) per the member's AMHH eligibility period.
- *Daily Respite Care:* The basic unit is a single-day unit, which applies to services provided between 8 and 24 hours within the same calendar day. Daily Respite Care may be provided for up to 14 consecutive days for a maximum of 28 days per eligibility period.

Hourly and daily Respite Care may not be billed on the same calendar day.

Section 20: Therapy and Behavioral Support Services

Adult Mental Health Habilitation (AMHH) Therapy and Behavioral Support Services consist of a series of time-limited, structured, face-to-face sessions that work toward the goals identified in the Individualized Integrated Care Plan (IICP). Services must be provided at the member's home (living environment) or at a location outside the clinic setting.

AMHH Therapy and Behavioral Support Services may be provided to:

- Members individually in individual or group settings
- Family members or other nonprofessional caregivers in individual or group settings, with or without the member present

See [Appendix A: AMHH Acronyms and Definitions](#) for the definitions of individual and group settings as they apply to this service.

Provider Qualifications

Providers of Therapy and Behavioral Support Services must have one of the following qualifications:

- Licensed professional, except for a licensed clinical addiction counselor
- Qualified behavioral health professional (QBHP)

For additional information about qualifications for provider agency and staff members, see [Section 3: AMHH Agency Staff Requirements](#).

Program Standards

Program standards for AMHH Therapy and Behavioral Support Services include the following:

- Services may be provided face to face with the member or with family members or nonprofessional caregivers with or without the member present.
- The member must be the focus of the treatment, and documentation must support how the service benefits the member.
- Services must address one or more goals identified in the IICP, and these goals must be habilitative.
- Documentation must demonstrate progress toward and achievement of treatment goals.
- Therapy and Behavioral Support Services include, but are not limited to, the following:
 - Observing the member and environment to help develop the IICP
 - Developing a person-centered behavioral support plan and subsequent revisions, which may be a part of the IICP
 - Implementing the behavior support plan for staff, family members, roommates, and other appropriate individuals
 - Training in assertiveness and/or relationship building
 - Addressing and managing behavioral health symptoms or impairment
 - Teaching stress-reduction techniques
 - Developing and retaining socially accepted behaviors

Exclusions

Exclusions to the general AMHH program are outlined in [Section 2: Adult Mental Health Habilitation \(AMHH\) Program Overview](#). The following exclusion applies and is nonreimbursable or noncovered for AMHH Therapy and Behavioral Support Services:

- Service provided in a clinic setting is not billable as an AMHH service (but may qualify for reimbursement as a Medicaid outpatient mental health service).

HCPCS Codes

Table 4 shows Healthcare Common Procedure Coding System (HCPCS) codes for Therapy and Behavioral Support Services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 4 – HCPCS Codes for Therapy and Behavioral Support Services

Code	Modifiers	Code Description	Limitations
H0004	UB	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation	Maximum is 24 hours (96 units) (1unit = 15 minutes) per eligibility period in an individual setting
H0004	UB HR	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; family/couple with client present	Maximum is 24 hours (96 units) (1unit = 15 minutes) per eligibility period in an individual setting
H0004	UB HS	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; family/couple without client present	Maximum is 24 hours (96 units) (1unit = 15 minutes) per eligibility period in an individual setting
H0004	UB U1	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; group	Maximum is 30 hours (120 units) (1unit = 15 minutes) per eligibility period in a group setting
H0004	UB U1 HR	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; group; family/couple with client present	Maximum is 30 hours (120 units) (1unit = 15 minutes) per eligibility period in a group setting
H0004	UB U1 HS	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; group; family/couple without client present	Maximum is 30 hours (120 units) (1unit = 15 minutes) per eligibility period in a group setting

Service Unit Description and Limitations

The basic unit of service for AMHH Therapy and Behavioral Support Services is a 15-minute unit. The available number of units per AMHH eligibility period is determined according to the setting (individual or group) in which the service was provided:

- When provided in an individual setting, including a combination of all three subtypes (member only, family/couple or caregivers with and without the member present), the service may be provided for a maximum of 24 hours (96 units) per year.
- When provided in a group setting, including combination of all three subtypes (multiple members, family/couple or caregivers with and without the member present), the service may be provided for a maximum of 30 hours (120 units) per year.

Section 21: Addiction Counseling

Adult Mental Health Habilitation (AMHH) Addiction Counseling services consist of a series of planned and organized face-to-face services in which addiction professionals and other clinicians provide counseling interventions that work toward the member's recovery goals identified in the Individualized Integrated Care Plan (IICP), as they pertain to substance-related disorders. Services must be provided at the member's home (living environment) or at other locations outside the clinic setting. Services under this section may be provided for members with a substance-related disorder with any of the following:

- Minimal or manageable medical conditions
- Minimal withdrawal risk
- Emotional, behavioral, and cognitive conditions that do not prevent the member from benefitting from this service

Note: When requesting Addiction Counseling services, the provider must ensure that a substance-use diagnosis is reflected in the applicant's Data Assessment Registry Mental Health and Addiction (DARMHA) record.

AMHH Addiction Counseling services may be provided to:

- Members individually in individual or group settings
- Family members or other nonprofessional caregivers in individual or group settings, with or without the members present

See [Appendix A: AMHH Acronyms and Definitions](#) for definitions of individual and group settings as they apply to this service.

Provider Qualifications

AMHH Addiction Counseling Services must be provided by qualified addiction professionals or other clinicians that have either of the following qualifications:

- Licensed professional, including a licensed clinical addiction counselor (LCAC)
- Qualified behavioral health professional (QBHP)

For additional information about qualifications for provider agency and staff members, see [Section 3: AMHH Agency Staff Requirements](#).

Program Standards

Program standards for AMHH Addiction Counseling services include:

- Services must be provided face-to-face with the member, family members, or nonprofessional caregivers supporting the member.
- The member must always be the focus of addiction counseling.
- Addiction counseling must consist of regularly scheduled sessions.
- Documentation must support how addiction counseling benefits the member and must demonstrate progress toward and achievement of goals identified in the IICP.

- Addiction Counseling services may include the following activities:
 - Education about addiction disorders (combined with other addiction-treatment activities)
 - Skills training in:
 - Communication
 - Anger management
 - Stress management
 - Relapse prevention
 - Referral to community recovery support programs, as available

Exclusions

Exclusions to the general AMHH program are outlined in [Section 2: Adult Mental Health Habilitation \(AMHH\) Program Overview](#). The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Addiction Counseling services:

- Services provided to members with withdrawal risk or symptoms
- Services provided to members whose needs cannot be managed safely with AMHH services
- Services provided to members who require detoxification services
- Services provided to members who are determined to be at imminent risk of harm to the self or to others
- Addiction counseling sessions that consist only of education services
- Services provided to professional caregivers

HCPCS Codes

Table 5 shows Healthcare Common Procedure Coding System (HCPCS) codes for Addiction Counseling services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 5 – HCPCS Codes for Addiction Counseling Services

Code	Modifiers	Code Description	Limitations
H2035	UB	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; individual	Maximum is 64 hours (64 units) (1 unit = 1 hour) per eligibility period
H2035	UB HR	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; family/couple with client present	Maximum is 64 hours (64 units) (1 unit = 1 hour) per eligibility period
H2035	UB HS	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; family/couple without client present	Maximum is 64 hours (64 units) (1 unit = 1 hour) per eligibility period
H2035	UB U1	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; group	Maximum is 16 hours (64 units) (1 unit = 15 minutes) per eligibility period

Code	Modifiers	Code Description	Limitations
H2035	UB U1 HR	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; group; family/couple with client present	Maximum is 16 hours (64 units) (1 unit = 15 minutes) per eligibility period
H2035	UB U1 HS	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; group; family/couple without client present	Maximum is 16 hours (64 units) (1 unit = 15 minutes) per eligibility period

Service Unit Description and Limitations

The basic unit of service for AMHH Addiction Counseling, individual, is a 1-hour unit. The service may be provided for a maximum of 64 hours (64 units) per eligibility period. All subtypes of Addiction Counseling services (group setting, family/couple with and without member present) may be provided for a maximum of 64 units (1 unit = 15 minutes), for a total of 16 hours per eligibility period.

Section 22: Peer Support Services

Adult Mental Health Habilitation (AMHH) Peer Support Services are face-to-face individual services, typically provided by a certified recovery specialist (CRS) and consisting of structured, scheduled activities promoting the following:

- Socialization
- Habilitation
- Recovery
- Self-advocacy
- Development of natural supports
- Maintenance or acquisition of community living skills

Provider Qualifications

Staff providers of Peer Support Services must have both the following qualifications:

- Meet the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) training and competency standards for a CRS
- Be under the supervision of a licensed professional or a qualified behavioral health professional (QBHP)

For additional information about qualifications for provider agency and staff members, see [Section 3: AMHH Agency Staff Requirements](#).

Program Standards

Program standards for AMHH Peer Support Services include:

- The service must be provided face-to-face with the member in an individual setting only.
- The service must be a structured and scheduled activity.
- The service must help the member obtain a specific treatment goal in the Individualized Integrated Care Plan (IICP) (that is, the IICP must contain a specific goal or objective to be directly addressed by peer support services).
- Documentation must support how the service specifically benefits the member.
- The service includes, at a minimum, one or more of the following components:
 - Helping the member develop a self-care plan (which may be included in the IICP), as well as other formal mentoring activities aimed at increasing the member's active participation in person-centered planning and delivery of individualized services
 - Helping the member develop psychiatric advanced directives
 - Supporting the member in problem-solving related to reintegration into the community
 - Educating the member about and promoting habilitation, the recovery process, and anti-stigma activities

Exclusions

Exclusions to the general AMHH program are outlined in [Section 2: Adult Mental Health Habilitation \(AMHH\) Program Overview](#). The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Peer Support Services:

- Services that are purely recreational or diversionary and do not support community integration goals
- Services provided in group settings
- Activities billed under AMHH Home and Community-Based Habilitation and Support Services or AMHH Care Coordination services

HCPCS Codes

Table 6 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Peer Support Services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 6 – HCPCS Codes for Peer Support Services

Code	Modifier	Code Description	Limitation
H0038	UB	Self-help/peer services, per 15 minutes; adult mental health habilitation	Maximum is 130 hours (520 units) (1 unit = 15 minutes) per eligibility period

Service Unit Description and Limitations

The basic unit of service for AMHH Peer Support Services is a 15-minute unit. Peer Support Services may be provided for a maximum of 130 hours (520 units) per AMHH eligibility period.

Section 23: Supported Community Engagement

Adult Mental Health Habilitation (AMHH) Supported Community Engagement Services are face-to-face activities delivered on an individual basis and in a community setting. This service is designed to engage members in meaningful community involvement activities, such as volunteerism or community service. Services are habilitative in nature and are aimed at developing skills and opportunities that lead to the members' improved integration into the community through increasing community engagement. AMHH Supported Community Engagement Services may not, however, include explicit employment objectives.

Provider Qualifications

Staff providers of Supported Community Engagement Services must have one of the following qualifications:

- Licensed professional
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

For additional information about qualifications for provider agency and staff members, see [Section 3: AMHH Agency Staff Requirements](#).

Program Standards

Program standards for AMHH Supported Community Engagement Services include the following:

- The service requires face-to-face contact with the member in a community setting.
- The service is provided to members who may benefit from community engagement and are unlikely to achieve this level of community integration without the provision of support.
- The service includes helping the member develop a relationship with community organizations specific to that individual's interests and needs.
- The service involves collaboration with a community organization to develop an individualized plan that identifies specific supports required, organizational expectations, training strategies, time frames, and responsibilities.
- Allowable activities are geared to achieving a generalized skill or behavior that may prepare the member for community engagement and may include (but not be limited to) teaching concepts such as:
 - Attendance
 - Task completion
 - Problem solving
 - Safety
- Services must be explicitly identified in the IICP and related to goals identified by the member, and may include activities such as:
 - How to use public transportation to get to and from the designated community setting
 - Work environment/modification analysis

- Work-task analysis – an activity intended to enhance the member’s functioning in a volunteer (community) setting and not an employment-related goal
- Use of assistive technology device/adaptive equipment

Note: Activities allowed under Supported Community Engagement Services are intended to engage members in meaningful community involvement through activities such as volunteerism or community service.

Activities allowed under Home and Community-Based Habilitation and Support Services are intended to focus on the maintenance of basic skills needed to live in the community.

Exclusions

Exclusions to the general AMHH program are outlined in [Section 2: Adult Mental Health Habilitation \(AMHH\) Program Overview](#). The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Supported Community Engagement Services:

- Reimbursement or compensation paid by the provider agency to the member for performing activities covered under the service. If a provider chooses to compensate a member for job-related activities, the provider must use non-Medicaid funding and must be able to document the funding source.
- Training in specific job tasks
- Services provided to members who are currently competitively employed
- Any service that is available as vocational rehabilitation services funded under the *Rehabilitation Act of 1973*
- Services provided in a group setting
- Services that include explicit employment objectives

HCPCS Codes

Table 7 shows Healthcare Common Procedure Coding System (HCPCS) codes for Supported Community Engagement Services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 7 – HCPCS Codes for Supported Community Engagement Services

Code	Modifier	Code Description	Limitations
97537	UB	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes; adult mental health habilitation	Maximum is 18 hours (72 units) (1 unit = 15 minutes) per month

Service Unit Description and Limitations

The basic unit of service for AMHH Supported Community Engagement Services is a 15-minute unit. Supported Community Engagement Services may be provided up to a maximum of 18 hours (72 units) per month.

Section 24: Care Coordination

Adult Mental Health Habilitation (AMHH) Care Coordination services consist of activities that help a member access needed medical, social, educational, and other services. These services include direct assistance in gaining access to services, coordination of care, oversight of the member's care in the AMHH program, and linkage to appropriate services.

AMHH Care Coordination includes the following activities:

- *Assessment to determine service needs:* Includes identifying the member's needs for medical, educational, social, or other services. Activities necessary to form a complete needs assessment of the member may include the following:
 - Documenting the member's history
 - Identifying the individual's needs
 - Completing related documentation
 - Gathering information from other sources, such as family members and medical providers
- *Development of the IICP:* Includes the development of a written Individualized Integrated Care Plan (IICP) based on the information collected through the needs assessment. The IICP identifies the habilitative activities and assistance needed to accomplish the member's identified goals and objectives.
- *Referral and Linkage:* Includes activities that help link the member with programs and services that are capable of providing needed habilitative services that meet the member's needs, including but not limited to:
 - Medical providers
 - Social service providers
 - Educational providers
 - Community providers
 - Other providers
- *Monitoring and Follow-up:* Includes contacts and related activities necessary to ensure the IICP is effectively implemented and adequately addresses the member's needs. Such activities and contacts may include the following:
 - The member
 - Family members or individuals who have a significant relationship with the member
 - Nonprofessional caregivers
 - Providers
 - Other entities
- *Evaluation:* Includes face-to-face contact with the member at least every 90 days for the following reasons:
 - To determine if services are being furnished in accordance with the IICP
 - To assess the adequacy of the services in the IICP
 - To assess any changes in the member's needs or status
 - To make changes or adjustments to the IICP to meet the member's ongoing needs
 - To evaluate or reevaluate the member's progress toward achieving the IICP's objectives

Note: Time devoted to formal supervision of the case between the care coordinator and a licensed supervisor to review the member's care and treatment is considered an included Care Coordination activity. The supervision must be documented appropriately and billed under one provider only.

Provider Qualifications

Provider staff delivering AMHH Care Coordination must have one of the following qualifications:

- Licensed professional
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

For additional information about qualifications for provider agency and staff members, see [Section 3: AMHH Agency Staff Requirements](#).

Program Standards

Program standards for AMHH Care Coordination services include the following:

- Care Coordination includes:
 - Development of the IICP
 - Limited referrals to services
 - Activities or contacts necessary to ensure that the IICP is effectively implemented and adequately addresses the mental health or addiction needs, or both, of the member
- Care Coordination does not include direct delivery of medical, clinical, or other direct services. It is provided on behalf of the member, not to the member.
- Care Coordination must provide direct assistance to the member in gaining access to necessary medical, social, educational, and other services.
- The care coordinator must reevaluate the member's progress via face-to-face contact with the member at least every 90 days to:
 - Ensure that the IICP is effectively implemented and adequately addresses the needs of the member
 - Determine whether the services are consistent with the IICP
 - Make changes or adjustments to the IICP to meet the member's ongoing needs
 - Evaluate or reevaluate the member's progress toward achieving the IICP's objectives

Exclusions

Exclusions to the general AMHH program are outlined in [Section 2: Adult Mental Health Habilitation \(AMHH\) Program Overview](#). The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Care Coordination services:

- Activities billed under behavioral health level of need redetermination (by a nonphysician)
- Services provided in a group setting
- Direct delivery of medical, clinical, or other direct services, including but not limited to the following:
 - Training in daily living skills
 - Training in work or social skills
 - Grooming and other personal services
 - Training in housekeeping, laundry, or cooking
 - Transportation services
 - Individual, group, or family therapy
 - Crisis intervention services

- Services that go beyond assisting the member in gaining access to needed services, including but not limited to the following:
 - Paying bills and balancing the member's checkbook
 - Traveling to and from appointments with members

HCPCS Codes

Table 8 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Care Coordination services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 8 – HCPCS Codes for Care Coordination Services

Code	Modifier	Code Description	Limitations
T1016	UB	Care Coordination, each 15 minutes; adult mental health habilitation	Maximum is 200 hours (800 units) (1 unit = 15 minutes) per eligibility period

Service Unit Description and Limitations

The basic unit of service for AMHH Care Coordination services is a 15-minute unit. Care Coordination services may be provided for a maximum of 200 hours (800 units) per eligibility period.

Some members who receive AMHH Care Coordination services will also be enrolled in the Behavioral and Primary Healthcare Coordination (BPHC) Program. This program provides specialized case management to assist in the coordination, referral, and linkage needs of a member with co-occurring mental and physical health concerns. For members approved for both AMHH and BPHC, the number of AMHH Care Coordination service units, or BPHC service units, will be adjusted as follows:

- For individuals who have active AMHH service package assignments at the time of BPHC application, the number of BPHC units is authorized based on the time left until the AMHH evaluation is due, as outlined in the following table. If the AMHH end date is less than 6 months away, the BPHC end date is aligned with the AMHH end date. If the AMHH end date is more than 6 months away, the BPHC service is authorized for 6 months. In both scenarios, the active AMHH authorization period remains unchanged.
- If an individual applies for AMHH after he or she already has an active BPHC service package assignment, the number of authorized AMHH Care Coordination units (T1016 UB) is reduced to account for the BPHC service package assignment.

Section 25: Medication Training and Support

Adult Mental Health Habilitation (AMHH) Medication Training and Support services involve face-to-face services provided to the member, in an individual or group setting, for the purpose of:

- Monitoring medication compliance
- Providing education and training about medications
- Monitoring medication side effects
- Providing other nursing or medical assessment

AMHH Medication Training and Support services may also include training family members and nonprofessional caregivers to assist with the member's medication management. When provided to family members or other nonprofessional caregivers (with or without the member present), the service:

- Must focus on and be on behalf of the member
- May include training family members or nonprofessional caregivers to:
 - Monitor the member's medication compliance
 - Assist with the administration of prescribed medications
 - Monitor side effects, including:
 - Weight
 - Blood glucose level
 - Blood pressure

AMHH Medication Training and Support services can be provided to:

- Members individually in individual or group settings
- Family members or other nonprofessional caregivers in individual or group settings, with or without the member present

For definitions of individual and group settings as they apply to this service, see [Appendix A: AMHH Acronyms and Definitions](#).

In addition to face-to-face services provided to a member or a member's family, some AMHH Medication Training and Support services are not required to be provided face-to-face. These services may be provided only in an individual setting and include:

- Transcribing medication orders of a physician or authorized healthcare professional (AHCP)
- Setting or filling medication boxes
- Consulting with the attending physician or AHCP regarding medication-related issues
- Ensuring that lab and other prescribed clinical orders are sent
- Ensuring that the member follows through and receives lab work and services pursuant to other clinical orders
- Follow-up reporting of lab and clinical test results to the member and physician

Provider Qualifications

Provider staff delivering AMHH Medication Training and Support services must be one of the following qualifications:

- Licensed physician
- Authorized healthcare professional (AHCP)
- Licensed registered nurse (RN)
- Licensed practical nurse (LPN)
- Medical assistant (MA) who has graduated from a 2-year clinical program

For additional information about qualifications for provider agency and staff members, see [Section 3: AMHH Agency Staff Requirements](#).

Program Standards

Program standards for AMHH Medication Training and Support services include the following:

- Services must be provided within the scope of practice, as defined by federal and State law.
- Services provided that are not face-to-face with the member must meet the following standards:
 - The member must be the focus of the service.
 - Documentation must support how the service benefits the member.
- When provided in a clinic setting, AMHH Medication Training and Support services may complement, but not duplicate, activities associated with medication management activities available as a Medicaid outpatient mental health service (as defined under *Indiana Administrative Code 405 IAC 5-20-8*).
- When provided in a residential treatment setting, AMHH Medication Training and Support services may include components of, but not duplicate, medication management services, as defined under the Medicaid outpatient mental health service (*405 IAC 5-20-8*).
- Services must be habilitative in nature and demonstrate movement toward and achievement of the member's treatment goals identified on the Individualized Integrated Care Plan (IICP).

Exclusions

Exclusions to the general AMHH program are outlined in [Section 2: Adult Mental Health Habilitation \(AMHH\) Program Overview](#). The following specific exclusions apply and are nonreimbursable or noncovered for AMHH Medication Training and Support services:

- If medication management, counseling, or psychotherapy is provided through the Medicaid outpatient mental health benefit, and medication management is a component of the service, then AMHH Medication Training and Support services may not be billed separately for the same visit by the same provider.
- Coaching and instruction regarding member self-administration of medications is not reimbursable under AMHH Medication Training and Support, but may be eligible for reimbursement under Home and Community-Based Habilitation and Support services skills training and development.
- Services provided to paid, professional caregivers are excluded.

- When provided in a group setting, the following activities are not covered:
 - Transcribing physician or AHCP medication orders
 - Setting or filling medication boxes
 - Consulting with the attending physician or AHCP regarding medication-related issues
 - Ensuring that a lab or other prescribed clinical orders are sent
 - Ensuring that the member follows through and receives lab work and services pursuant to other clinical orders
 - Follow-up reporting of lab and clinical test results to the member and physician

HCPCS Codes

Table 9 shows the Healthcare Common Procedure Coding System (HCPCS) codes for Medication Training and Support services. For a complete list of AMHH service codes and rates, see [Appendix H: AMHH Service Codes and Rates Table](#).

Table 9 – HCPCS Codes for Medication Training and Support Services

Code	Modifiers	Code Description	Limitations
H0034	UB	Medication training and support, per 15 minutes; adult mental health habilitation	Maximum is 182 hours (728 units) (1 unit = 15 minutes) per eligibility period
H0034	UB HR	Medication training and support, per 15 minutes; adult mental health habilitation; family/couple with the client present individual setting	Maximum is 182 hours (728 units) (1 unit = 15 minutes) per eligibility period
H0034	UB HS	Medication training and support, per 15 minutes; adult mental health habilitation; family couple without the client present individual setting	Maximum is 182 hours (728 units) (1 unit = 15 minutes) per eligibility period
H0034	UB U1	Medication training and support, per 15 minutes; adult mental health habilitation; group setting	Maximum is 182 hours (728 units) (1 unit = 15 minutes) per eligibility period
H0034	UB U1 HR	Medication training and support, per 15 minutes; adult mental health habilitation; group setting; family/couple with the client present	Maximum is 182 hours (728 units) (1 unit = 15 minutes) per eligibility period
H0034	UB U1 HS	Medication training and support, per 15 minutes; adult mental health habilitation; group setting; family/couple without the client present	Maximum is 182 hours (728 units) (1 unit = 15 minutes) per eligibility period

Service Unit Description and Limitations

The basic unit of service for AMHH Medication Training and Support services is a 15-minute unit. AMHH Medication Training and Support services, including all subtypes (individual or group setting, family/couple, with and without member present), may be provided for a maximum of 182 hours (728 units) per AMHH eligibility period.

Section 26: AMHH Program Billing

This section outlines Adult Mental Health Habilitation (AMHH) billing guidelines, claim format, and necessary billing-related information. Explanation of billing specifics, such as actual time spent conducting service versus time billed, modifiers, and other helpful billing-related items, are included with examples. For more information about general billing, see *Indiana Administrative Code 405 IAC 1* and the provider reference modules on the [IHCP Provider Reference Modules](#) page at in.gov/medicaid/providers. Indiana Health Coverage Programs (IHCP) providers are responsible for reading and understanding applicable IAC and IHCP modules.

Note: The IHCP [Provider Healthcare Portal \(Portal\)](#), accessible from the home page at in.gov/medicaid/providers, is an interactive web application that allows providers to submit claims and attachments, check eligibility, and check status of claims. The Portal is fast, free, and does not require special software. Providers must register on the Portal to use the Portal to submit claims, verify member eligibility, and maintain enrollment data. See the [Provider Healthcare Portal](#) module for more information.

Billing Standards

AMHH provider agencies that are enrolled IHCP providers must adhere to all IHCP rules, policies, and processes required of IHCP-enrolled members.

In regard to AMHH services, the following applies:

- IHCP rendering provider numbers are assigned to physicians or health service providers in psychology (HSPPs). The rendering provider numbers are linked to the group provider number of the participating billing group.
- Reimbursement is 100% of the rate for all staff that meet provider qualifications for each service.
- Providers are responsible for internally tracking AMHH service utilization to ensure that service units are available. Providers can confirm service unit availability via the Portal, the State's recognized final reference for this information.
- Units of AMHH services, as displayed in the Portal, are decremented based on adjudicated claims. Failure to submit claims in a timely fashion may place the provider at risk for nonpayment.
- For an AMHH provider to receive reimbursement for the delivery of AMHH services, a member must have been deemed eligible for AMHH services and received an authorization notification confirming the AMHH services authorized on the Individualized Integrated Care Plan (IICP). The Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) State Evaluation Team (SET) retains final authority for determining AMHH eligibility and authorizing AMHH services.
- AMHH approval and authorization dates may be accessed by providers on the Portal.
- Providers of AMHH services are IHCP providers and, therefore, are responsible for complying with IHCP billing practices outlined in the provider reference modules on the [IHCP Provider Reference Modules](#) page at in.gov/medicaid/providers.

Claim Submission Guidelines

Claims for AMHH services are billed on a professional claim (paper *CMS-1500* claim form, Portal professional claim, or 837P electronic transaction). Paper copies of the *CMS-1500*, Version 02/12 form are available from the U.S. Government Bookstore or other online retailers. Instructions for completing the form are in the [Home and Community-Based Services Billing Guidelines](#) and [Claim Submission and Processing](#) modules.

Providers bill services based on an approved Notice of Action (NOA) for the individual member, using an appropriate procedure code, modifier and the pricing method associated with the procedure code, such as per unit, per day, or per month. Additional pricing information is available on the Professional Fee Schedule, accessible from the [IHCP Fee Schedules](#) page at in.gov/medicaid/providers.

General billing guidelines include:

- Do not bill for services before they are provided.
- If a unit of service equals 15 minutes, a minimum of 8 minutes must be provided to bill for one unit.
- Activities requiring less than 8 minutes may be accrued to the end of that date of service.
- At the end of the day, partial units may be rounded as follows: units totaling 8 or more minutes may be rounded up and billed as one unit.
- Partial units totaling less than eight minutes may not be billed.
- Monthly units are billed at the end of the month.
- Daily units may be billed daily, weekly, or monthly.

The following instructions must be followed for billing claims to the IHCP for AMHH services:

- The provider agency's group National Provider Identifier (NPI) must be entered in as the **billing provider NPI** (field 33a of the *CMS-1500* claim form).
- Each service-detail of the claim must include the NPI of the rendering or supervising psychiatrist, physician, or HSPP as the **rendering provider NPI** for the service (field 24J of the *CMS-1500* claim form).

Note: Submit claims for reimbursement on a timely basis:

- *Units of AMHH services as displayed in the Portal are decremented based on adjudicated claims.*
- *Timely submission of claims ensures that the data accessible on the Provider Healthcare Portal accurately reflects remaining units of service for each member.*
- *Failure to submit claims timely may place the provider at risk for nonpayment.*

AMHH services may be billed with other IHCP-covered services on the same claim. Updated information is disseminated through IHCP provider bulletins posted at [News, Bulletins, and Banner Pages](#) at in.gov/medicaid/providers. Each provider is responsible for obtaining the information, and implementing new or revised policies and procedures as outlined in these notices.

Facility Fees

No facility fees are paid for AMHH services.

AMHH and the Healthy Indiana Plan (HIP)

Individuals who are enrolled in the Healthy Indiana Plan (HIP) and who are determined to be medically frail have access to coverage established under the Indiana Medicaid State Plan. The State Plan services include intensive behavioral health Medicaid programs such as Medicaid Rehabilitation Option (MRO) and Behavioral and Primary Healthcare Coordination (BPHC), as well as AMHH. The intensive community-based behavioral health service programs are carved out from the HIP managed care entities (MCEs) benefit responsibilities and are billed to the IHCP through the fee-for-service claim payment system.

A member enrolled in *HIP Basic* who is determined medically frail is transferred to *HIP State Plan – Basic* benefits, whereas a member enrolled in *HIP Plus* who is determined medically frail is transferred to *HIP State Plan – Plus*. *HIP State Plan – Basic* and *HIP State Plan – Plus* are provided by the same managed care entities (MCEs) and have the same cost-sharing structures as the standard *HIP Basic* and *HIP Plus* plans. In *HIP State Plan – Basic*, the member is required to pay a \$4 copay for outpatient services, including many AMHH services. In *HIP State Plan – Plus*, members are not subject to copays for most services, including all AMHH behavioral health services. Table 10 identifies the AMHH service types that do not require copayment under *HIP State Plan – Basic*.

Table 10 – AMHH Services That Do Not Require a Copayment under *HIP State Plan – Basic*

Procedure Code	Modifiers	Code Description
H2014	UB HS	Skills training and development, per 15 minutes; adult mental health habilitation; family/couple without client present
H2014	UB U1 HS	Skills training and development, per 15 minutes; adult mental health habilitation; group setting; family/couple without client
H0004	UB HS	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; family/couple without client present
H0004	UB U1 HS	Behavioral health counseling and therapy, per 15 minutes; adult mental health habilitation; group; family/couple without client present
H2035	UB HS	Alcohol and/or other drug treatment program, per hour; adult mental health habilitation; family/couple w/o client present
H2035	UB U1 HS	Alcohol and/or other drug treatment program, per hour; adult mental health habilitation; group setting; family/couple without the client present
H0038	UB	Self-help/peer services, per 15 minutes; adult mental health habilitation
T1016	UB	Care Coordination, each 15 minutes; adult mental health habilitation
H0034	UB	Medication training and support, per 15 minutes; adult mental health habilitation
H0034	UB HR	Medication training and support, per 15 minutes; adult mental health habilitation; family/couple with the client present individual setting
H0034	UB HS	Medication training and support, per 15 minutes; adult mental health habilitation; family couple without the client present individual setting
H0034	UB U1	Medication training and support, per 15 minutes; adult mental health habilitation; group setting
H0034	UB U1 HR	Medication training and support, per 15 minutes; adult mental health habilitation; group setting; family/couple with the client present
H0034	UB U1 HS	Medication training and support, per 15 minutes; adult mental health habilitation; group setting; family/couple without the client present

For more information about the HIP program, see the [FSSA HIP website](https://www.in.gov/fssa/hip) at [in.gov/fssa/hip](https://www.in.gov/fssa/hip).

Time Documentation

Staff must document actual time spent delivering services in a given 24-hour period in the member's clinical record. For billing purposes, a provider agency must total the actual time spent delivering the same service on the same day by all provider types for each member. Minutes of service do not have to be consecutive to be billed together. When services are provided in group settings, it is appropriate to bill for each member in the group for the time spent in the group. Figure 6 shows examples of time documentation.

Figure 6 – Examples of Time Documentation

Example A-1:

A member receives 5 minutes of Home and Community-Based Habilitation and Support services from a staff member, 4 minutes of Home and Community-Based Habilitation and Support services from a second staff member, and 9 minutes of Home and Community-Based Habilitation and Support services from a third staff member on the same day. The member's clinical record notes that three staff members provided Home and Community-Based Habilitation and Support services on the same day and the amount of time each staff person spent with the member. For time documentation purposes, the total actual time spent is 18 minutes.

$$5 \text{ minutes} + 4 \text{ minutes} + 9 \text{ minutes} = 18 \text{ minutes of Home and Community-Based Habilitation and Support services}$$

Example A-2:

A member receives 15 minutes of Therapy and Behavioral Support Services, individual, from a licensed clinical social worker (LCSW) and 25 minutes of Therapy and Behavioral Support Services, individual, from a master's level practitioner on the same day. The member's clinical record notes that two staff members provided Therapy and Behavioral Support Services, individual, on the same day and the amount of time each staff person spent with the member. For time documentation purposes, the total actual time spent is 40 minutes. Even though the two staff members have different provider qualifications, they must add their time spent with the member together.

$$15 \text{ minutes} + 25 \text{ minutes} = 40 \text{ Minutes of Therapy and Behavioral Support Services, individual}$$

Converting Time Spent for Service Delivery to Billing Units

Providers must determine the total actual time spent delivering a service in a given 24-hour period (see Figure 6). The total time spent is then converted into billing units for that service. Providers should refer to the Healthcare Common Procedure Coding System (HCPCS) code for each service for information on the unit increment that is used for each service. Providers should round the total actual time each day to the nearest whole unit when calculating reimbursement, described in the following sections.

15-Minute Unit

Services billed in 15-minute units include:

- Home and Community-Based Habilitation and Support
- Therapy and Behavioral Support Services
- Peer Support Services
- Supported Community Engagement Services

- Care Coordination
- Medication Training and Support
- Respite Care (may also be billed in single-day units, as described in the [Single-Day Units](#) section)

If staff delivers one of these services for 8 or more minutes, or the total daily minutes for the service add up to 8 or more minutes, the provider may round up to one 15-minute unit (Figure 7). If staff delivers a service for 7 minutes or less, or the total daily minutes for the service add up to 7 minutes or less, the provider rounds down to zero units and therefore, may not bill for the service. The same rounding rules apply to portions of time remaining after one or more entire 15-minute units have been converted.

Figure 7 – Examples of 15-Minute Billing

Example B-1:

The member from the preceding Example A-1 ([Figure 6](#)) received 18 total minutes of Home and Community-Based Habilitation and Support services from three different staff members in a 24-hour period, as reflected in the member's clinical record. Home and Community-Based Habilitation and Support services are billed in 15-minute units, so for billing purposes, only 1 unit of Home and Community-Based Habilitation and Support services may be billed.

18 minutes of Home and Community-Based Habilitation and Support services = One 15-minute unit of Home and Community-Based Habilitation and Support services (one full 15-minute unit plus 3 additional minutes, which must be rounded down)

Example B-2:

The member (from the preceding Example A-2 in [Figure 6](#)) received 40 minutes of Therapy and Behavioral Support services, individual, from two different providers on the same day, as reflected in the member's clinical record. Therapy and Behavioral Support services are billed in 15-minute units, so for billing purposes, 3 units of Therapy and Behavioral Support services may be billed.

40 Minutes of Therapy and Behavioral Support services = Three 15-minute units of Therapy and Behavioral Support services (2 full 15-minute units plus 10 additional minutes, which may be rounded up)

One-Hour (60-Minute) Unit

AMHH Addiction Counseling services are billed in 1-hour (60-minute) units (Figure 8). If staff delivers Addiction Counseling for 45 or more minutes, or the total minutes of Addiction Counseling provided for the day add up to 45 or more minutes, the provider may bill for the appropriate number of units of Addiction Counseling. If staff delivers Addiction Counseling for 44 minutes or less, or the total minutes of Addiction Counseling provided for the day add up to 44 minutes or less, the provider rounds down to zero units and therefore, may not bill for this service. The same rounding rules apply to portions of time remaining, after one or more entire 1-hour (60-minute) units have been converted.

Figure 8 – Example of 1-Hour Unit Billing

Example C-1:

A member receives 48 minutes of Addiction Counseling services, individual. For billing purposes, 48 minutes of service is greater than (>) the 44-minute threshold, and the provider may round up to one 1-hour unit.

48 minutes > 44-minute threshold = Provider may bill for one 1-hour unit of Addiction Counseling services.

Example C-2:

A member receives 25 minutes of Addiction Counseling services. For billing purposes, 25 minutes of service is less than (<) the 44-minute threshold. The provider must round down to zero (0) and may not bill for this service.

25 minutes < 44 minutes = provider may not bill for Addiction Counseling services rendered.

Example C-3:

A member receives 20 minutes of Addiction Counseling individual services from one staff member and 25 minutes of Addiction Counseling group services from a second staff member on the same day. The provider totals the actual time delivering the service to 45 minutes. For billing purposes, 45 minutes of service is greater than the 44-minute threshold, and the provider rounds up to one 1-hour unit.

20 minutes + 25 minutes = 45 minutes > 44 minutes threshold = Provider may bill for one 1-hour unit of Addiction Counseling services.

Example C-4:

A member receives 80 minutes of Addiction Counseling services, group. For billing purposes, 80 minutes is greater than the 44-minute threshold for one 1-hour unit of service but does not qualify for a second 1-hour unit of service.

80 minutes = 60 minutes (one 1-hour unit of service) + 20 minutes;

20 minutes < 44-minute threshold = Provider may bill for one 1-hour unit of Addiction Counseling services, and may not bill the additional 20 minutes of services rendered.

Half-Day Units

AMHH Adult Day Services is the only AMHH service that is billed in half-day units, which consist of a minimum of 3 and maximum of 5 consecutive hours of the service (Figure 9). Up to 20 minutes in break time may occur within the minimum 3-hour block of service time. If more than 3 consecutive hours are provided, up to a 60-minute break is allowed in addition to the 20-minute break. The 60-minute break may not be billed as a component of the service, however.

Adult Day Services allows for up to 2 half-day units of service to be billed in one day. The second half-day unit may be billed only if a previous half-day unit equaling 5 hours has been delivered and an additional 3 hours of the service is provided. The second unit of service may include an additional 20-minute break within the 3-hour block of time.

Figure 9 – Example of Half-Day Unit Billing

Example D-1:

A member receives 53 minutes of Adult Day Services followed by a 10-minute break, an additional 50 minutes of Adult Day Services followed by a 10-minute break, and finally, an additional 60 minutes of Adult Day Services. A total of 163 minutes of member contact was provided, and with the allowable 20 minutes of break time, a total of 183 minutes of Adult Day Services was delivered (183 minutes is greater than [$>$] the 180 minute unit).

183 minutes $>$ 180 minutes = Provider may bill for one half-day unit of Adult Day services.

Example D-2:

A member receives 30 minutes of Adult Day Services followed by a 10-minute break, then an additional 30 minutes of Adult Day Services, followed by a 10-minute break, and finally an additional 30 minutes of Adult Day Services. A total of 90 minutes of member contact was provided, and with the allowable 20 minutes of break time, a total of 110 minutes of Adult Day Services was delivered (110 minutes is less than [$<$] the 180-minute unit).

110 minutes $<$ 180 minutes = Provider may not bill for the Adult Day Services rendered.

Single-Day Units

AMHH Respite Care may be billed in two separate ways, depending on the length of time the service was provided during a 24-hour period (Figure 10). Respite Care is billed in 15-minute units when provided 7 hours or less per day, and in single-day units when the service is provided for a minimum of 8 hours, up to a maximum of 24 hours in a 1-day period.

Note: Hourly Respite Care and Daily Respite Care may not be billed on the same date of service.

Figure 10 – Examples of Respite Care Billing

Example E-1:

A member receives 204 minutes of Respite Care in a calendar day, which equates to 3 hours and 24 minutes. Because this is less than 7 hours, the provider may bill for total of fourteen 15-minute units of “hourly rate” Respite Care.

3 hours x 4 units/hour = 12 units, plus 24 minutes = one 15-minute unit plus 9 additional minutes, rounded up to another whole unit, totaling 14 units

Example E-2:

A member receives 14 hours of Respite Care services in a calendar day. Because this is more than 7 hours, the provider may bill for one single-day unit of Respite Care.

Modifiers for AMHH Services

Providers must use the appropriate modifiers in Table 11 when submitting AMHH claims.

Table 11 – AMHH Service Modifiers

Modifier	Description
U1	Group setting
HR	Family/couple with client present
HS	Family/couple without client present
UB	Face-to-face encounter

Midlevel provider modifiers should **not** be used when submitting AMHH services claims. Using midlevel provider modifiers results in denials of AMHH services claims.

Place of Service Codes

AMHH services can be rendered in the following locations with the place of service code listed:

- 12 – Home
- 99 – Other unlisted facility (such as employment or a community place)
- 53 – Community mental health center (CMHC)

Mailing Address for Claims

AMHH paper claims are sent to the standard fee-for-service medical claim address:

CMS-1500 Claims
P.O. Box 7269
Indianapolis, IN 46207-7269

Third-Party Liability (TPL) Requirements

The IHCP will not bill private insurance carriers through the third-party liability (TPL) or reclamation processes for claims containing any HCBS benefit modifiers, including modifiers specific to AMHH services.

HCBS Audits

The state of Indiana employs a hybrid program integrity (PI) approach to overseeing HCBS programs, incorporating oversight and coordination by the Surveillance and Utilization Review (SUR) Unit, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) contractor arrangements. The FSSA has expanded its PI activities using a multifaceted approach to SUR activity that includes provider self-audits, desk audits, and on-site audits. SUR is required to complete an initial assessment of each provider type annually. Then, based on the assessment information and referrals, audits are completed as needed. The FADS team analyzes claims data, allowing them to identify providers and claims that indicate aberrant billing patterns and other risk factors.

The PI audit process uses data mining, research, identification of outliers, problematic billing patterns, aberrant providers, and issues that are referred by other divisions and State agencies. In 2011, the state of Indiana formed a Benefit Integrity Team, composed of key stakeholders that meet biweekly to review and approve audit plans and provider communications, and make policy and system recommendations to affected program areas. The SUR Unit also meets with all HCBS divisions on a quarterly basis, at a minimum, and receives referrals on an ongoing basis to maintain open lines of communication and understanding in specific areas of concern, such as policy clarification.

The SUR HCBS specialist is a subject-matter expert (SME) responsible for directly coordinating with the HCBS divisions. This specialist also analyzes data to identify potential areas of risk and identify providers that appear to be outliers warranting review. The SME may also perform desk or on-site audits and be directly involved in reviewing HCBS providers and programs.

Throughout the entire PI process, the FSSA maintains oversight. Although the FADS contractor may be incorporated in the audit process, no audit is performed without the authorization of the FSSA. The FSSA's oversight of the contractor's aggregate data is used to identify common problems to be audited, determine benchmarks, and offer data to peer providers for educational purposes, when appropriate.

The SUR Unit offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with federal and State guidelines, including all IHCP and HCBS requirements.

FSSA Audit Oversight

The Audit Division of the FSSA reviews HCBS audit team schedules and findings to reduce redundancy and assure use of consistent methodology.

Medicaid Fraud Control Audit Overview

The Indiana Medicaid Fraud Control Unit (MFCU) is an investigative branch of the Attorney General's Office. MFCU conducts investigations in the following areas:

- Medicaid provider fraud
- Misuse of Medicaid members' funds
- Patient abuse or neglect in Medicaid facilities

When the MFCU identifies a provider that has violated regulations in one of these areas, the provider's case is presented to the State or federal prosecutors for appropriate action. Access information about the [MFCU](https://www.in.gov/attorney-general/) at [in.gov/attorney general](https://www.in.gov/attorney-general/).

Contact Information

Providers should direct questions about filing claims to Customer Assistance at 1-800-457-4584. The addresses and telephone numbers are also available on the [IHCP Quick Reference Guide](#) at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).

Appendix A: AMHH Acronyms and Definitions

The following acronyms and definitions apply to Adult Mental Health Habilitation (AMHH) services and the policies and procedures outlined in this module.

837P electronic transaction allows providers to submit professional claims electronically to the IHCP. The 837P transaction can be used instead of the Provider Healthcare Portal professional claim or the *CMS-1500* paper claim form.

Adult Mental Health Habilitation (AMHH) refers to medical or remedial services recommended by a licensed professional, as well as QBHP, within the scope of his or her practice, for the habilitation of a mental disability and the restoration or maintenance of an individual's best possible functional level. Services are clinical and supportive behavioral health services that are provided for individuals, families, or groups of adult persons who are living in the community and who need aid on a routine basis for a mental illness or co-occurring mental illness and addiction disorders. AMHH services include the following:

- Adult Day Services
- Home and Community-Based Habilitation and Support
- Respite Care
- Therapy and Behavioral Support Services
- Addiction Counseling
- Peer Support Services
- Supported Community Engagement Services
- Care Coordination
- Medication Training and Support

Adult Needs and Strengths Assessment (ANSA) is the approved Division of Mental Health and Addiction (DMHA) behavioral health assessment tool, administered by a qualified individual who is trained and DMHA-certified to administer the tool, to assist in determining the level of need and functional impairment of an applicant or member.

Aged and Disabled (A&D) Waiver provides an alternative to nursing facility admission for people who are aged, blind, or disabled. There is no age requirement to qualify for this waiver. The waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility if waiver services or other supports were not available.

Applicant means an individual applying for AMHH services by inquiring about AMHH services or completing the AMHH application process.

Assistance means any kind of support given due to a behavioral health condition or disorder. This support includes but is not limited to the following:

- Mentoring
- Supervision
- Reminders
- Verbal cueing
- Hands-on assistance

Authorized healthcare professional (AHCP) means any of the following persons:

- A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of *Indiana Code IC 25-27.5-5*
- A nurse practitioner or clinical nurse specialist with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician, pursuant to *IC 25-23-1*

Care coordinator means the DMHA-approved AMHH provider staff overseeing or managing the AMHH service member's case while the individual is enrolled in the AMHH program.

Centers for Medicare & Medicaid Services (CMS) is the federal agency that has authority over the 1915(i) State plan amendments in each state. The CMS must approve the State's requests to implement the federally funded State Plan Amendment and all subsequent program amendments and funding.

Certified community health worker (CHW) refers to an individual who is certified to deliver services as defined at *405 IAC 5-21.8-8(a)*. To be certified as a CHW, an individual must have completed the CHW DMHA and Indiana State Department of Health State-approved training program and received a passing score on the certification exam. The CHW is supervised by a licensed professional or qualified behavioral health professional (as defined in this section) and remains in good standing.

Certified recovery specialist (CRS) refers to an individual who is certified to deliver services as defined at *405 IAC 5-21.8-8(f)*. To be certified as a CRS, an individual must be maintaining healthy recovery from mental illness and must have completed the CRS DMHA State-approved training program and received a passing score on the certification exam. The CRS is supervised by a licensed professional or qualified behavioral health professional (as defined in this section) and remains in good standing.

CMS-1500 is the CMS-authorized professional claim form used to submit paper claims to the Medicaid fiscal contractor for reimbursement of rendered, DMHA-approved HCBS services.

Community-based refers to AMHH services that are approved by the Centers for Medicare & Medicaid Services (CMS) to be provided within the individual's home (or place of residence), or at other locations based in the community (outside institutional settings). For more information regarding community-based settings, see [Section 6: AMHH Member Home and Community-Based Settings Requirements](#).

Community Integration and Habilitation (CIH) Waiver provides services that enable individuals with developmental disabilities to remain in their homes or in community settings and assists people who transition from state-operated facilities or other institutions into community settings. This waiver is designed to provide supports for persons to gain and maintain optimum levels of self-determination and community integration while allowing flexibility in the provision of those supports.

Community mental health center (CMHC) is approved as such by the DMHA under *440 IAC 4.1-2-1*. The centers offer communities access to a full continuum of behavioral health services.

Consumer Service Line is a toll-free line for consumers to share complaints, questions, and concerns about services, treatments, procedures, rights, and policies. The line is open Monday-Friday from 8:30 a.m. to 5 p.m. The DMHA contractor processes calls and informs the DMHA. The toll-free number is 1-800-901-1133. Deaf, hard-of-hearing, or speech-impaired individuals can dial 7-1-1 to access the Consumer Service Line.

CoreMMIS is Indiana's Medicaid Management Information System (MMIS), or claim-processing system, which replaced IndianaAIM.

Data Assessment Registry Mental Health and Addiction (DARMHA) supports the use of information about the strengths and needs of individuals to help make decisions, to monitor progress and to improve quality. DARMHA is also the system by which the AMHH application is entered and submitted to the DMHA for review.

Detoxification services means services or activities that are provided to a member during his or her withdrawal from alcohol and other addictive drugs, while under the direct supervision of a physician or clinical nurse specialist.

Division of Aging (DA) is the division within the Indiana Family and Social Services Administration (FSSA) that oversees two 1915(c) Home and Community-Based Services (HCBS) waiver programs: the Aged and Disabled (A&D) Waiver and the Traumatic Brain Injury (TBI) Waiver. The Division of Aging is also responsible for administering the Money Follows the Person (MFP) demonstration grant and processing Preadmission Screening and Resident Review (PASRR) requests.

Division of Family Resources (DFR) is the division within the Indiana Family and Social Services Administration (FSSA) responsible for processing applications and approving eligibility for Medicaid, Temporary Aid for Needy Families (TANF, or cash assistance), child care assistance, Supplemental Nutrition Assistance Program (SNAP, or food stamps), and employment and training services for low-income clients.

Division of Mental Health and Addiction (DMHA) refers to the division under the Indiana Family and Social Services Administration (FSSA) that oversees the implementation and ongoing monitoring of the AMHH program, which is provided by the DMHA's State-certified CMHCs.

DXC Technology (DXC) is the Indiana Medicaid fiscal agent responsible for maintaining the Core Medicaid Management Information System (*CoreMMIS*) database for all Medicaid participants, provider enrollment, authorized Indiana Health Coverage Programs (IHCP) services, IHCP claim processing, and reimbursement for eligible IHCP providers. This includes all approved HCBS participants, DMHA-approved services, and enrolled providers of HCBS. DXC assigns all IHCP Provider IDs required for reimbursement of all IHCP claims. DXC also maintains the IHCP provider reference modules for all IHCP providers.

Family and Social Services Administration (FSSA) is the Indiana state agency that includes the Division of Aging (DA), Division of Disability and Rehabilitation Services (DDRS), Division of Family Resources (DFR), Division of Mental Health and Addiction (DMHA), and Office of Medicaid Policy and Planning (OMPP).

Family Supports Waiver (FSW) provides limited, nonresidential supports to individuals with developmental disabilities who live with their families or in other settings with informal supports.

Group setting means that the activity is meant to benefit more than one client, and may include family members and nonprofessional caregivers of multiple clients, whether or not the clients are present during the activity. The benefit to the client must be in accordance with each client's individual treatment goals.

Example: The families of several clients meet for an orientation session to an upcoming AMHH skills development group, which will be attended by several AMHH clients. Because the group includes more than one client, the orientation is considered a group setting.

Habilitation services means activities that are designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in community settings.

Health means physical and behavioral well-being.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) refers to mandated requirements for the adoption of national standards for healthcare, including the protection of health information and standard unique identifiers for all healthcare providers, as well as coding healthcare services for approving, billing, reimbursing, and tracking.

Health service provider in psychology (HSPP) as defined by *IC 25-33-1*.

Home and Community-Based Services (HCBS) refers to services approved by the Centers for Medicare & Medicaid Services (CMS) to be provided within Medicaid member's home (or place of residence) or at

other locations based in the community (outside the institutional setting). For Medicaid purposes, *HCBS* generally refers to home and community-based services programs authorized by CMS under Section 1915(c) of the *Social Security Act*.

Indiana Administrative Code (IAC) refers to the Indiana State policies and procedures.

Indiana Code (IC) consists of Indiana State statutes that govern the IAC.

Indiana Health Coverage Programs (IHCP) is Indiana's Medicaid program, collectively referred to as the Indiana Health Coverage Programs (IHCP). The IHCP provides a healthcare safety net for low-income children and adults, including those who are aged, disabled, blind, pregnant, or meet other eligibility requirements. The IHCP receives federal and State funds to operate the program and reimburse providers for reasonable and necessary medical care for eligible members. Each state administers its own Medicaid program within the provisions of federal legislation and broad federal guidelines issued by the Centers for Medicare & Medicaid Services (CMS). The Indiana Family and Social Services Administration (FSSA) administers the IHCP. The IHCP includes the 590 Program, Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise (including Children's Health Insurance Program), and Traditional Medicaid.

Individual provider is a provider that practices privately and not under an agency.

Individualized Integrated Care Plan (IICP) means a treatment plan that:

- Integrates all components and aspects of care that are:
 - Deemed medically necessary
 - Needs-based
 - Clinically indicated
 - Provided in the most appropriate setting to achieve the member's goals
- Includes all indicated medical and support services needed by the member to:
 - Remain in the community
 - Function at the highest level of independence possible
 - Achieve goals identified in the IICP
- Is developed for each member
- Is developed with the member
- Reflects the member's desires and choices
- Identifies the individual's diagnosis, treatment goals, interventions, progress/outcomes, strengths, objectives

Individual setting means the activity is meant to benefit one client, even though the activity may include family members and nonprofessional caregivers, and the client may or may not be present during the activity.

Example: An AMHH client, "John," attends a family counseling session with his siblings and mother. Since the session is intended to benefit only John, it is considered an individual setting, even though multiple people are present.

Level of need (LON) means a recommended intensity of behavioral health services based on a pattern of an individual's and family's needs, as determined as determined by using the DMHA-approved behavioral health standardized assessment tool (the Adult Needs and Strengths Assessment or ANSA).

Licensed professional means any of the following persons:

- Licensed physician (including licensed psychiatrist)
- Licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP)
- Licensed clinical social worker (LCSW)

- Licensed mental health counselor (LMHC)
- Licensed marriage and family therapist (LMFT)
- Licensed clinical addiction counselor (LCAC), as defined under *IC 25-23.6-10.5*

Managed care entity (MCE) is an entity contracted to provide and manage benefits for members enrolled in a managed care program, such as the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise. In a full-risk contract, the MCE agrees to provide all benefits on a per-member per-month basis, known as full capitation.

Medicaid Rehabilitation Option (MRO) services means any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a member to his or her best possible level of functioning.

Member means an individual who has been approved by the DMHA SET to receive AMHH services and has Medicaid.

Member ID is the member identification number, also known as RID, used to identify individuals eligible for Indiana Health Coverage Programs (IHCP) services, including tracking and claim processing for eligible services.

Money Follows the Person is a demonstration grant to help move individuals from institutional settings to home and community-based settings.

Needs-based eligibility criteria are factors used to determine an applicant's requirement for AMHH service activities. The applicant meets the AMHH needs-based eligibility criteria when the following is demonstrated:

- Needs related to management of his or her health
- Impairment in self-management of health services
- A health need that requires assistance and support in coordinating health treatment
- A recommendation for intensive community-based care based on the uniform DMHA-approved behavioral health assessment tool, as indicated by a rating of 4 or higher

Nonprofessional caregiver means any individual who does not receive compensation for providing care or services to a Medicaid member.

National Provider Identifier (NPI) is the 1996 HIPAA-mandated standard unique identifier for all healthcare providers. Unique NPIs are assigned by application to the National Plan and Provider Enumeration System that collects identifying information on healthcare providers. (**Note:** An assigned NPI is not needed for AMHH service providers that do not perform healthcare services. HCBS providers may submit claims using their Provider ID.)

Office of Medicaid Policy and Planning (OMPP) is the division within the Indiana Family and Social Services Administration (FSSA) that administers the Indiana Health Coverage Programs in accordance with federal and State requirements, which includes responsibility for financial oversight of the HCBS program.

Other behavioral health professional (OBHP) means any of the following:

- An individual with an associate's or bachelor's degree, or equivalent behavioral health experience, meeting minimum competency standards set forth by a behavioral health service provider and supervised by a licensed professional or a QBHP
- A licensed addiction counselor, as defined under *IC 25-23.6-10.5*, supervised by a licensed professional or a QBHP

Outpatient mental health services are services defined under 405 IAC 5-20-8, formerly referred to as “Medicaid Clinic Option” services.

Participant refers to an individual who has been deemed eligible for HCBS services by the DMHA.

Professional caregiver means an individual who receives payment for providing services and supports to a Medicaid member.

Provider agency means any the DMHA state-certified CMHC that meets required qualifications and criteria that can employ rendering providers to deliver the AMHH services.

Provider Healthcare Portal is a secure, web-based tool where AMHH authorization, claim, and other information may be viewed by AMHH providers. Provider enrollment, provider profile updates, and claims (including claims for DMHA-approved CMHW services rendered) may also be submitted via the Portal. The [Portal](https://in.gov/medicaid/providers) is accessible from the home page at in.gov/medicaid/providers. For more information about using the Portal, see the [Provider Healthcare Portal](#) module.

Provider ID is a unique identifier, formerly referred to as the Legacy Provider Identifier (LPI), assigned to IHCP-enrolled providers, including service providers, for submission of all claims for IHCP reimbursement. This number is assigned by the Medicaid fiscal agent during the provider enrollment process.

Provider staff means any individual working under a DMHA-approved AMHH provider agency that meets the qualifications and requirements mandated by the AMHH service being provided.

Qualified behavioral health professional (QBHP) means any of the following:

- An individual who has had at least 2 years of clinical experience treating persons with mental illness under the supervision of a licensed professional, with such experience occurring after the completion of a master’s degree or doctoral degree, or both, in any of the following disciplines from an accredited university:
 - Psychiatric or mental health nursing, plus a license as a registered nurse in Indiana
 - Pastoral counseling
 - Rehabilitation counseling
- An individual who is under the supervision of a licensed professional, is eligible for and working towards professional licensure, and has completed a master’s or doctoral degree, or both, in any of the following disciplines from an accredited university:
 - Social work from a university accredited by the Council on Social Work Education
 - Psychology
 - Mental health counseling
 - Marital and family therapy
- A licensed independent practice school psychologist under the supervision of a licensed professional
- An authorized health care professional (AHCP) who is one of the following:
 - A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5
 - A nurse practitioner or clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person’s license and under the supervision of, or under a supervisory agreement with, a licensed physician, pursuant to IC 25-23-1

Recreational means activities people do to relax or have fun (for example, activities done for enjoyment).

Residential Settings Screening Tool (RSST) is DMHA’s HCBS form used to screen for HCBS compliance in a member’s current living situation.

Self-help means self-guided improvement in functioning through the use of supports and resources.

Significant means an assessed need for immediate or intensive action due to a serious or disabling need.

Skills training means services or activities to further the reinforcement, management, adaptation, and retention of skills necessary for the individual to live successfully in the community.

State Evaluation Team (SET) means the DMHA independent evaluation team that reviews and assesses all evaluation information and supporting clinical documentation collected for AMHH applications and members, and is responsible for making final determinations regarding the following:

- Eligibility of applicants for AMHH services
- Authorization for AMHH services for eligible members
- Continued eligibility determination for AMHH members
- Appropriate service delivery to AMHH members, as a result of conducting quality improvement reviews of AMHH service provider agencies

Traumatic Brain Injury (TBI) Waiver provides services to Medicaid-eligible people of any age who have experienced an external event resulting in a traumatic brain injury and who require services ordinarily available only in a nursing facility.

Appendix B: AMHH-Eligible Primary Mental Health and Substance Abuse Diagnosis Codes

Adult Mental Health Habilitation (AMHH)-eligible members must have one or more AMHH-eligible primary mental health diagnoses, as outlined in [Section 5: AMHH Program Member Eligibility](#).

The AMHH-eligible primary mental health diagnosis codes (ICD-10) are available on the *Adult Mental Health Habilitation Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Appendix C: AMHH Application Screen Shots

This appendix provides information about completing each page of the AMHH application.

Page 1 – General

The first page of the AMHH application appears under the General tab. Figure 11 shows the top portion of the first page, Figure 12 shows the middle portion, and Figure 13 shows the bottom portion. The information required in each section follows each figure.

Figure 11 – AMHH Application – General (Top Portion)

Top left box: Information in the top left box is automatically imported from the applicant's record. All the imported information must be checked for accuracy and, if necessary, corrections made in the member's DARMHA record before the application is submitted.

- A green check mark next to an item means the AMHH eligibility criteria is met for that item.
- A red X next to an item means the AMHH eligibility criteria is not met for that item.

Applicant Information: The current, physical home address must be entered in the Home Address 1 box. If there is a P.O. Box address, it can be entered in the Address 2 box. This address is the home mailing address to which the member's AMHH approval or denial notice is sent; therefore, it is critical that this information is accurate. Applicants must be asked where they prefer to receive AMHH notices. If the member is homeless, or does not have or is unwilling to provide an address, the CMHC address may be entered, if the member consents. The telephone number must be entered in the AMHH application (the member's email address is *not* required).

When “Yes” is selected for the Medicaid enrolled item, the Current MRO Service Package Level must be selected from the pull-down menu. The Current MRO Package End Date field is required if MRO Service Package Level 3, 4, 5, or 5A is chosen; a calendar box pops up to assist.

The HCBS Address field allows for easier identification of whether the address provided in Home Address 1 has been identified by the CMHC as a residential setting in which the applicant resides. If a green check mark appears in this field, then the setting is identified by the CMHC. If the residential setting has not been identified by the CMHC, a red X will auto-populate.

Figure 12 – AMHH Application – General (Middle Portion)

The consumer is on one of the following waivers:

Current Living Situation :

Community-based Settings:

- ☐ Homeless
- ☐ Private/Independent Home
- ☐ Non-POCO Residential Setting
- ☐ POCO Residential Setting
- ☐ Non-CMHC POCO Residential setting
- ☐ Potential Presumed Institutional setting

Institutional Settings:

- ☐ Nursing Home
- ☐ Hospital
- ☐ Institution for Mental Disease (IMD)
- ☐ ICF/IID
- ☐ Jail or Correctional Facility

(Click to Select)

- Community Integration and Habilitation Waiver
- Family Supports Waiver
- Aged and Disabled Waiver
- Traumatic Brain Injury Waiver
- Money Follows the Person
- Unknown whether consumer is on waiver
- Consumer is on a waiver, unsure which waiver
- Not on a waiver

HCBS Waivers: An AMHH applicant must be asked if he or she is participating in an HCBS waiver. As described in [Section 2: Adult Mental Health Habilitation \(AMHH\) Program Overview](#), AMHH service providers are responsible, in collaboration with waiver providers, for monitoring services of AMHH members also enrolled in a 1915(c) waiver program to prevent service duplication. Using the pull-down menu, the AMHH provider must select from the following options:

- Community Integration and Habilitation Waiver
- Family Supports Waiver
- Aged and Disabled Waiver
- Traumatic Brain Injury Waiver
- Money Follows the Person
- Unknown whether member (consumer) is on waiver

Note: This “unknown” option should be selected only if the question has been asked of the applicant, and he or she is uncertain. All AMHH applicants must be asked this question.

- Member (consumer) is on waiver, unsure which waiver
- Not on a waiver

Current Living Situation: Select the circle next to the applicable current living situation **as of the day the application is being completed**. For definitions of community-based and institutional settings, see [Section 4: AMHH Member Home and Community-Based Settings Requirements](#) and [Section 7: Completing the HCBS Residential Setting Screening Tool](#) in this module.

For members who live in a community-based setting, provider agency staff completing the AMHH application must ensure that the setting selected on the DARMHA application is the same as the outcome

from the completed HCBS RSST. Applications for which the selected current living situation is not correct or is inconsistent will be pending for clarification. This section also links to the HCBS Address area to ensure consistency of identified POCO residential setting throughout the assessment process.

Figure 13 – AMHH Application – General (Bottom Portion)

Description of the Living Situation (Required for all living situations) :	
Describe the applicant's current living situation (as of the date of application), including the features of the housing situation that ensure it meets criteria for a home and/or community-based setting. If the applicant is currently in an institutional setting but is being discharged to the community within 90 days, please provide anticipated discharge date and expected living situation post-discharge.	
Justification of Need for Program (Current/Historical Physical and Behavioral Health) :	
Assessment of progress toward meeting treatment goals during existing AMHH eligibility period :	
Contact Person:	
Edit	Case Manager
Edit	Alternate Provider Contact
Edit	Psychiatrist
Edit	Caregiver/Guardian
<input type="button" value="Discard AMHH Application"/> <input type="button" value="Save as Draft"/> <input type="button" value="Submit"/> <input type="button" value="Back to Search"/> <input type="button" value="Previous Page"/> <input type="button" value="Next Page"/>	

Description of the Living Situation: Required on all applications, for all living situations. Applicants must be currently living in a community-based setting, as defined by the CMS; *or* the applicant may be in an institutional setting, as long as an anticipated discharge date is within 90 days and the applicant will be discharged to a community-based setting. The specific anticipated discharge date must be included in this section.

Justification of Need for Program: This section is crucial for establishing how and why the member will benefit more from a habilitative, rather than a rehabilitative, approach to care. The narrative may resemble a condensed biopsychosocial summary and must establish and demonstrate that the applicant meets the AMHH target and needs-based criteria. It may include (but is not limited to) the following information:

- Historical and current health status
- Behavioral health issues
- Current living situation
- Functional needs
- Family functioning
- Vocational/employment status
- Social functioning

- Living skills
- Self-care skills
- Capacity for decision making
- Potential for self-injury or harm to others
- Substance use or abuse
- Experience and response to rehabilitative services and the outcomes from those services
- Medication adherence

Information regarding the applicant's participation in any prior rehabilitative services and the outcomes from participation in those services must also be documented in this section of the application.

Example of Justification of Need for Program:

Jane is a 49-year-old female who resides with her parents. She has been living with her parents all of her life. Her bicycle is her primary means of transportation. She needs to maintain safety by using her bicycle in a safe manner. Currently, she rides it in the middle of the street, even on busy streets. She needs to be educated about her medical and psychiatric diagnoses (Schizophrenia, Generalized Anxiety Disorder) and encouraged to take medications as prescribed. She needs assistance with managing her mental health symptoms and with managing her financial funds to prevent her from being exploited, as provider ABC serves as her payee. Due to her frequent infections, Jane would benefit from regular engagement with service providers who can monitor her physical and mental health, ensure access to a laundromat, and help her obtain supplies for arts and crafts to manage anxiety. Jane is trying to have her felonies expunged, which will assist with housing attainment. She needs to follow up with medical recommendations surrounding suspicious spots found on her lungs. Her family has a history of health problems, including cancer. She needs reminders to use her oxygen as prescribed. Her psychiatrist recommends addiction treatment and counseling for Jane, due to occasional cocaine use. Jane stated "I would like to live on my own...instead of living in a group home." She is optimistic about the future and has strong family support.

Assessment of progress toward meeting treatment goals during existing AMHH eligibility period: This narrative box appears only on renewal applications for members who are already enrolled in AMHH and are applying for another annual eligibility period. For additional information about what providers are expected to include in this narrative, see [Section 12: Renewal of AMHH Program Member Eligibility](#).

Contact Person: Primary and alternate case managers, as well as the attending psychiatrist, must be identified. The Caregiver/Guardian field must be completed, if applicable. Choose **Edit** next to each member role; enter name, telephone number, and email; and then choose **Update** to save the information. The application may not be submitted until all required information is entered.

Page 2 – IICP Form

The second page of the AMHH application is the Individualized Integrated Care Plan (IICP) Form. It consists of five sections, which are accessed by clicking on the blue underlined "wizard" links on the left side of the application.

Strengths

Figure 14 shows an expanded view of the Strengths wizard. The Strengths wizard displays all items imported from the Strengths domain of the ANSA attached to the application that were scored 0 or 1, indicating the most stable and useful strengths identified by the applicant.

Figure 14 – IICP Form – Strengths

AMHH Application View

General **IICP Form**

IICP No. : New Application

[Strengths](#)
[Needs](#)
[Services](#)
[Attestations](#)
[Trans to MRO](#)

Strengths (Pulled from most recent ANSA)

☐ Strengths Domain

Optimism (Hopefulness)	0	Individual has a strong and stable optimistic outlook on his/her life. Individual is future oriented.
Community Connection	1	This level indicates an individual with significant community ties and/or support although they may be relatively short-term (i.e., past year).
Resourcefulness	1	Individual has some skills at finding necessary resources required to aid in a healthy lifestyle, but sometimes requires assistance at identifying or accessing these resources.

Strengths Statement :

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Strengths Statement: The person completing the application must provide a narrative summary (“Strengths Statement”) of the applicant’s most relevant and supportive strengths when living in the community.

Example of Strengths Statement:

Jane identifies her relationship with her parents as her greatest strength. Jane’s parents provide emotional support and companionship, as well as attending to almost all the household tasks and chores. Jane receives Supplemental Security Income (SSI), Supplemental Nutrition Assistance Program (SNAP), and Medicaid, so her basic needs are addressed. Jane is able to prepare simple foods (sandwiches, cereal, and so on) that do not involve cooking, and can bathe herself, though she requires prompting to do so.

The Strengths wizard’s display may be toggled between expanded and collapsed views by clicking the plus sign (to expand) or minus sign (to collapse) next to “Strengths Domain.”

Functional Needs

Figure 15 shows a partially expanded view of the Needs wizard. It displays all items imported from the Life Functioning, Acculturation, Behavioral Health Needs, and Risk Behaviors domains of the ANSA.

Figure 15 – IICP Form – Needs

Functional Needs (Pulled from most recent ANSA)	
<input checked="" type="checkbox"/> Life Functioning Domain	
<input type="checkbox"/> Behavioral Health Needs Domain	
Psychosis (Thought Disturbance)	2 <i>This rating indicates an individual with evidence of moderate disturbance in thought process or content. The individual may be somewhat delusional or have brief or intermittent hallucinations. The person's speech may be at times quite tangential or illogical.</i>
Impulse Control	2 <i>This rating is used to indicate an individual with moderate impulse control problems. An individual who meets DSM-IV diagnostic criteria for impulse control disorder would be rated here. Persons who use poor judgment or put themselves in jeopardy would be rated here (e.g., picking fights).</i>
Needs Statement :	
<div style="border: 1px solid black; height: 80px;"></div>	
Goal :	
<div style="border: 1px solid black; height: 80px;"></div>	
Objectives :	
1. Objectives - what I will do <div style="display: flex;"> <div style="width: 20px; text-align: center;"> </div> <div> I will follow up with Dentist and have my teeth checked. I will cut back the amount of sugar I put in my ice tea to one cup per gallon of </div> </div>	
Insert New Row	

Needs Statement: The person completing the application must provide a narrative summary of the applicant's needs.

Example of Needs Statement:

Jane's needs are in the areas of self-care, finding sobriety, physical and financial safety, and assistance with following medical advice pertaining to her mental and physical health needs. Jane is unable to complete most activities of daily living, especially when she is in the community, due to her persistent critical auditory hallucinations and paranoia, as well as her chronic anxiety. She relies almost exclusively on her parents to manage her needs. Her parents also remind her to take her medication on schedule, and she requires the use of a medication planner to ensure that she takes her multiple medications correctly. Jane is somewhat passive and usually requires prompting and encouragement to leave her home to attend appointments with providers and complete other business.

The Needs wizard's display may be toggled between expanded and collapsed views by clicking the plus sign (to expand) or minus sign (to collapse) next to each Functional Needs domain.

Goal and Objectives narrative boxes: Goals and objectives for AMHH applicants and members must be habilitative. The goals and objectives are intended to promote stability and potential movement toward independence and integration into the community, treatment of mental illness symptoms, and habilitating areas of functional deficits related to the mental illness. Goals are ideally presented in the member's own words, and must reflect the member's desires and choices. Staff clarification of goals should be added, when needed. Goals should be reflected in the objectives and AMHH services selected. Objectives are intended to support maintenance of previously learned skills and the preservation of the individual's current (best) level of functioning. Objectives should take into consideration the client/member goals and should align with the selected AMHH services.

Example of Goal and Objectives:

Goal: Jane states, “I want to live on my own, not with my parents. I still use cocaine but I want to stop. My psychiatrist has recommended addiction treatment but I don’t know how to get started.”

Objectives:

- Jane will continue to meet with treatment team members at least five times per week for the nurse to help fill her medication planner and monitor medication compliance, to keep psychiatric symptoms and their impact on her behavioral functioning manageable as evidenced by staff and self-reports.
- Jane will remain abstinent from cocaine, as evidenced by self-report and random drug screenings. Jane will attend weekly Cocaine Anonymous groups until she feels ready for addiction counseling as reported by staff and self-reports.
- Jane will use care coordination to establish regular meetings with health professionals as required, including an oncologist; and her primary care provider to take preventative measures with other health concerns as they arise. This includes evaluation, monitoring and follow-up with medical and other services/social services for Jane as evidenced by staff and self-reports.
- Jane will use community support and engagement services to seek out meaningful and volunteer opportunities to enhance her positive engagement in her community. Her goal is to manage her critical auditory hallucinations and decrease her anxiety by being involved in activities and events that distract her from internal troubling voices and keep her calm, as evidenced by staff and self-reports.
- Jane will work with her parents and staff to develop and retain alternative options to help her stay safely in the community as evidenced by staff and self-reports.

Services Being Requested

Figure 16 shows the Services wizard. Each service requested by and on behalf of the applicant is selected in this wizard. Additional information about the scope of each service is provided in *Sections 16–24* of this module.

For each service selected, the person completing the application must provide a narrative summary of how the service will help the applicant attain one or more of the goals and objectives specified in the previous section of the IICP.

Figure 16 – IICP Form – Services

IICP No. : New Application

[Strengths](#)
[Needs](#)
[Services](#)
[Attestations](#)

Services Being Requested (Put narrative on each service selected) :

Describe how the requested service will help applicant attain specified goal(s) and objectives from IICP, as well as any other services that may be accessed by the applicant to meet the identified goal/objective (i.e., clinic option services, family/natural supports, etc.).

☐ Adult Day Services (S5101)

☐ Home and Community-Based (HCB) Habilitation and Support (H2014)

☐ Respite Care (S5150/S5151)

☐ Therapy and Behavioral Support Services (H0004)

☐ Addiction Counseling (H2035)

☐ Peer Support Services (H0038)

☐ Supported Community Engagement Services (97537)

☐ Care Coordination (T1016)

☐ Medication Training and Support (H0034)

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Services are selected by clicking in the corresponding box. A narrative box is made available to describe how the services will assist the member in reaching his or her identified goals/objectives.

All IICPs must be developed with the applicant and individualized to meet his or her identified needs (see [Section 9: Individualized Integrated Care Plan \(IICP\) Development for AMHH Services](#) in this module for additional information on IICP development). The “Provider Name” will default to the provider agency submitting the application. If the applicant chooses a different provider agency to provide the requested services, the chosen agency must be selected from the Provider Name pull-down menu.

Examples of Narrative Summaries for Selected Services:

Adult Day Service: Jane will attend A Hand Up adult day program, which is held at the agency main clinic Monday-Friday. The program includes:

- Daily low-impact exercise, nutritional education, and guidance
- Health monitoring
- Social skills development activities
- Supervised medication administration
- Activities of daily living (ADL) training, such as personal hygiene, meal preparation, and budgeting and financial support.

Participation in this program will help Jane meet her identified goal of moving into a place of her own by reinforcing and learning new skills needed to:

- Attend to her personal and household needs
- Work to sustain her daily medication compliance

Home and Community-Based Habilitation and Support: Jane relies on the staff and her parents to assist with reminders to take medication and follow up on medical recommendations; household *management* including cooking, cleaning, shopping, paying bills, and other chores; and accompanying her into the community, as needed. Medicaid Rehabilitation Option (MRO) services have helped Jane acquire a moderate degree of skill and competence to safely complete certain ADLs, with prompting and supervision. Jane would benefit from ongoing habilitation support and skills maintenance and reinforcement, to maximize her ability to use her previously learned skills to meet these responsibilities on her own, or with a greater degree of independence. At times, this service would also include her parents to provide additional training, support, and education on how to monitor and encourage Jane's participation in and completion of daily living activities, medication adherence, weight loss efforts, and symptom management as part of the preparation of moving into her own home. Providing support and encouragement for Jane to be able to independently complete some ADLs and engage in community activities, would help Jane meet her identified goals.

Respite Care: Jane's grandparents are elderly and live out-of-state. Her parents must sometimes travel out-of-state to help care for them and check on their safety. During these times, Jane has a tendency to miss medication, skip scheduled appointments, isolate in the home, which in the past, led to episodes of decompensation, increased anxiety, and sometimes resulted in hospitalizations. Having temporary respite care available to Jane when her parents are out of town would help avoid future decompensation and hospitalizations.

Therapy and Behavioral Support Services: Jane, and occasionally her parents, will meet with a home-based counselor for therapy and behavioral support. Jane and her parents will practice healthy communication and reinforcement patterns, engage in problem-solving activities, and have a supported environment in which to resolve differences. Jane will refresh and practice coping, distress, and tolerance skills she learned previously. Jane's parents will learn ways to recognize impending conflicts and support Jane in her efforts. *Addiction Counseling:* Jane will meet with an addiction counselor to begin to assess her readiness for change with regard to her cocaine use. Jane states she is motivated to stop using cocaine, but recognizes she does not know the first step to take to ensure she remains free from cocaine. Emphasis will be placed on Jane's using and retaining current skills and learning alternate coping skills to reduce her reliance on cocaine.

Peer Support: Jane will meet with an agency certified recovery specialist (CRS) to:

- Increase Jane's involvement in meaningful community activities
- Help facilitate Jane's attendance at adult day services by engaging and prompting her to use the bus, and making introductions at the day center
- Help Jane locate 12-step meetings (should she choose to go)

Jane has shared that she does not like "going out with doctors and counselors and stuff," because it makes her feel self-conscious and anxious. She is more willing to attend activities when, as she puts it, "Someone like me is there, instead of somebody that's just there because they get paid to be."

Supported Community Engagement: Jane's symptoms of paranoia are a significant barrier to her engaging in community activities, and frequently to even leaving her home. Her care coordinator often accompanies her into the community on occasions when she must leave home for appointments. Jane acknowledges that her paranoia interferes with her ability to be engaged in the community, and recognizes that when she is engaged in activities or is (comfortably) around other people, her auditory hallucinations are much easier to manage and ignore. Jane has expressed a desire to begin to seek out activities outside her home to help occupy her time and "help keep the voices quiet." Jane needs support to seek out, make connections in, and begin to engage in community activities, and to provide some reality testing and reinforcement of previously learned anxiety management techniques. She has a deep love of animals, so this service will be used to link and support Jane in developing regular meaningful community integration activities or volunteerism that involves her primary area of interest (animals), with the support of staff. A long-term goal will be to build on successes and gradually increase Jane's frequency and type of community engagement to meet her identified goal.

Care Coordination: Jane sees a primary care doctor and an oncologist for management of her medical issues. In addition, she receives SSI and Medicaid, and must maintain eligibility for these benefits. Due to her psychotic symptoms, Jane's ability to schedule and attend appointments, obtain and provide necessary information and documentation to providers, and identify and connect to community resources is extremely limited. Trying to seek out and connect to these resources on her own has previously been unsuccessful and anxiety-provoking, leading to an exacerbation of her mental health symptoms. Jane will need ongoing assistance coordinating her medical and psychiatric care, reminders for completing required activities to retain eligibility for disability benefits, and linkage to community resources to help meet other needs as they arise, to avoid decompensation and hospitalization.

Medication Training and Support: Jane has not demonstrated compliance with her medications without extensive support but would like to improve and is open to suggestions. Jane will work with the agency Assertive Community Treatment (ACT) team nurses to assist Jane in filling her medication planner weekly. The team nurses will also ensure that lab and other prescribed clinical orders are sent, ensure that Jane follows through and receives lab work and services pursuant to other clinical orders (including those ordered by providers outside the agency), and ensure follow-up reporting of lab and clinical test results to Jane and her various providers. Team nurses will also ensure that Jane's required lab results are sent to her pharmacy, so that Jane can receive refills of her medications in a timely fashion. This service would at times include her parents (her primary caregivers) to provide additional education and training about Jane's medications, to monitor their effectiveness and identify any side effects.

Attestations

Figure 17 shows the Attestation wizard. Ten required activities must be completed before the application is submitted. Included in the application is the required acknowledgement that the attestations have been fulfilled, signed by the appropriate individuals, and entered on the application:

AMHH provider agencies must maintain the actual documentation with signatures in the clinical record.

Figure 17 – IICP Form – Attestations

General	IICP Form	Application Status	History Logs
IICP No. : 1026 Version # : 2 Date Created : 7/27/2018 2:02:08 PM By: test, admin			DMHA Approved
Strengths Needs Services Attestations			
Treatment Team Attestation :			
<input checked="" type="checkbox"/> The applicant has been given choice of providers <input checked="" type="checkbox"/> The applicant has been given choice of services <input checked="" type="checkbox"/> The proposed IICP is individualized to meet the applicant's need <input checked="" type="checkbox"/> The applicant has participated in the development of the IICP <input checked="" type="checkbox"/> A copy of the IICP that was submitted with this application was offered to the applicant and/or legal guardian <input checked="" type="checkbox"/> Program requirements, including financial requirements, have been reviewed with the applicant <input checked="" type="checkbox"/> The HCBS Residential Setting Screening Tool has been completed with the applicant, a signed copy retained in the clinical record, and the HCBS Member Information Pamphlet was provided to the applicant			
<div align="right"> Date Attested Applicant : 07/27/2018 Legal Guardian : 07/27/2018 Referring Care Coordinator : 07/27/2018 Super User : 07/27/2018 </div>			
Why applicant did not sign (Please explain below) : <div style="border: 1px solid black; height: 50px; width: 100%;"></div>			
Psychiatrist/HSPP Attestation :			
<input checked="" type="checkbox"/> The services requested and the IICP are deemed appropriate, clinically indicated and medically necessary, and are based on the identified needs of the applicant <input checked="" type="checkbox"/> Without ongoing habilitation services the applicant will likely deteriorate and be at risk of institutionalization <input checked="" type="checkbox"/> Applicant is not a danger to self or others at the time this application is submitted			
<div align="right"> Date Attested Psychiatrist/HSPP : 07/27/2018 </div>			

Table 12 includes a description of each attestation, and who must sign for verification:

Table 12 – Required Attestations

Attestation	Individual Who Must Sign for Verification
The applicant has been given a choice of providers, which applies to choice in the provider agency and providers within an agency itself.	The applicant and/or legal guardian and the case manager/referring care coordinator
The applicant has been given choice of services to be provided.	The applicant and/or legal guardian and the case manager/referring care coordinator
The proposed IICP is individualized to meet the applicant's needs.	The applicant and/or legal guardian and the case manager/referring care coordinator
The applicant has participated in developing the IICP.	The applicant and/or legal guardian and the case manager/referring care coordinator
A copy of the IICP that was submitted with this application was offered to the applicant and/or legal guardian.	The applicant and/or legal guardian and the case manager/referring care coordinator
Program requirements, including financial requirements, have been reviewed with the applicant.	The applicant and/or legal guardian and the case manager/referring care coordinator
The HCBS Residential Setting Screening Tool (RSST) has been completed with the applicant, a signed copy retained in the clinical record, and the HCBS Member Information Pamphlet was provided to the applicant.	The applicant and/or legal guardian and the case manager/referring care coordinator
The services proposed on the IICP are deemed appropriate and medically necessary by the appropriate authority.	The psychiatrist or HSPP
The psychiatrist or HSPP attestation regarding the imminent likelihood that without ongoing habilitation services, the applicant will likely deteriorate and be at risk of institutionalization (for example, acute hospitalization, state hospital, nursing home, or jail).	The psychiatrist or HSPP
The applicant is not a danger to self or others at the time this application is submitted.	The psychiatrist or HSPP
<i>Note: In addition to the preceding attestations, a signature from the ANSA SuperUser reviewing the ANSA must be documented. The date the SuperUser signs the attestation documenting his or her review must be entered in the application.</i>	

Hard-copy or electronic signatures from the applicant, staff, legal guardian (if applicable), reviewing ANSA SuperUser, and the attending psychiatrist/HSPP must be kept in the member's clinical chart and made available for review by the State Evaluation Team (SET) upon request. The date of the signature on the attestation must be prior and within 60 days of the application submission date.

Transition to MRO

The Trans to MRO wizard (Figure 18) is visible only after a member's AMHH application is approved by the SET and processed by DXC Technology (DXC). It is used if a member opts to transition to MRO services from AMHH services.

Figure 18 – IICP Form – Transition to MRO

AMHH Application View

General **IICP Form**

IICP No. : **New Application**

[Strengths](#)
[Needs](#)
[Services](#)
[Attestations](#)
[Trans to MRO](#)

Request transition to MRO:

Date of Attestation :

[Clear Attestation Date](#)

☐ An ANSA has been completed in the past 60 days.

☐ Transition to MRO

Support Summary :

Provide information about the reason(s) consumer opted to transition back to MRO services.

[Previous](#)

[Discard AMHH Application](#) [Save as Draft](#) [Submit](#) [Back to Search](#) [Previous Page](#) [Next Page](#)

An ANSA must be completed in DARMHA **no more than 60 days** prior to the transition date for MRO eligibility to be determined and an MRO package assigned. If it has been more than 60 days, DXC will not assess for MRO eligibility, and the member may lose **all** services.

The person completing the application must check the box attesting that an ANSA has been completed **and submitted in DARMHA** no more than 60 days before the request to transition to MRO. The person completing the application must also check the “Transition to MRO” box and enter the date the member requested to transition to MRO in the “Date of Attestation” field. Brief information about the reason for the transition must be included in the “Support Summary” narrative box. See [Section 14: Transitions during AMHH Eligibility Period](#) for additional information.

Note: The member’s attestation of his or her choice to transition to MRO must be captured via hard-copy or electronic signature.

Application Status

The Application Status tab allows the SET to perform various actions, including the following:

- Approve or deny the application and the requested services and, if necessary, decrement service hours.
- View the service package dates.
- Communicate among SET members (Internal Comments) and with the provider (External Comments).

History Logs

The History Logs tab displays the current status of the application with date and time stamps for each action. It is the responsibility of the provider to monitor the application status until the application shows *HP Processed*. See [Table 13](#) for a description of each status.

Appendix D: CMHC Provider Application and Attestation to Provide AMHH Services

This appendix presents the provider agency requirements and expectations required to become an AMHH service provider agency as well as the application and attestation form required.

Provider Agency Application

To become an AMHH service provider agency, the CMHC must complete and submit a *CMHC Provider Agency Application and Attestation to Provide Adult Mental Health Habilitation Services* (see [Figure 19](#)), acknowledging that the agency will adhere to AMHH program policy and State requirements for all AMHH service providers. The completed provider application is submitted to the DMHA director's office for review for approval or denial.

The DMHA documents approval or denial of the CMHC's application to become an AMHH provider agency. If the agency is approved as an AMHH provider agency, the DMHA notifies the IHCP to add specialty 115 – *AMHH Service Provider* to the CMHC's existing provider profile.

Approvals are valid for 3 years. When possible, the DMHA aligns the AMHH provider agency renewal process with the routine CMHC certification time line. CMHCs that are approved to provide AMHH services need to be sure to comply with rules and regulations noted on the [Home and Community-Based Services \(HCBS\)](#) page at in.gov/fssa/dmha.

Provider Agency Requirements

All provider agencies must be approved by the DMHA, be an enrolled Medicaid provider, and meet the following AMHH provider agency criteria and standards:

- Be a DMHA-certified CMHC in good standing, including adherence to criteria required of all DMHA-certified CMHCs who offer the full continuum of care
- Have acquired and maintain a national accreditation by an entity approved by the DMHA
- Be an enrolled IHCP provider (see the [Provider Enrollment](#) module)
- Attest that they are willing and able to provide AMHH services, as described in the AMHH [State Plan](#) benefit, *Indiana Administrative Code 405 IAC 1-5-1* and *405 IAC 1-5-3*, and the AMHH provider module, including but not limited to:
 - Maintain documentation in accordance with IHCP requirements defined in *405 IAC 1-5-1* and *405 IAC 1-5-3*, and outlined in the provider modules for all IHCP providers.
 - Meet all AMHH provider agency criteria, as defined in the AMHH SPA and *405 IAC 5-21.6*.
 - Employ individual providers that are eligible to provide AMHH services. See the [Agency Staff Requirements](#) section for additional provider staff eligibility requirements.

Provider Agency Expectations

DMHA approval of an agency as an IHCP-enrolled AMHH provider agency is contingent on that agency complying with all IHCP and AMHH program rules and policies. In addition to meeting the requirements for IHCP-enrolled providers of AMHH services, all AMHH provider agencies must ensure that members are provided access to all the services and supports needed to meet members' individualized needs. AMHH provider agencies must:

- Provide information related to AMHH services, members, and agency staff, as required or requested by the DMHA.
- Ensure that all direct care agency staff members providing AMHH services to members meet all standards and qualifications required for the AMHH service being provided. CMHCs are responsible for maintaining accurate and up-to-date files for each staff member, including but not limited to proof of training.
- Actively participate in the DMHA quality assurance program, ensuring compliance with all performance criteria set forth for the AMHH program. As required by the State, the agency must participate in any quality improvement initiatives as they relate to the AMHH program.
- Participate in AMHH provider agency meetings, trainings, conference calls, and webinars provided or authorized by the DMHA.
- Comply with DMHA requirements regarding the reporting of critical incidents.
- Provide a system throughout its agency and network for handling individual complaints and appeals, including informing members of the availability of a toll-free number for reporting complaints to the State and the telephone number for the Indiana Protection and Advocacy Services Commission.
- Cooperate fully with the processing of any AMHH-related complaint or appeal, including any grievance plan or correction initiated by the State.
- Be compliant with all federal *Health Insurance Portability and Accountability Act (HIPAA)* and *Code of Federal Regulations 42 CFR Part 2* mandates and regulations in regards to client privacy and information sharing.
- Meet all clinical and operational standards and State requirements for a DMHA-certified CMHC, as found in *440 IAC 4.1*.
- Maintain written policies and procedures for timely intake, screening, and comprehensive evaluation from the time a referral for AMHH services is received, to ensure that members have access to appropriate mental health and addiction treatment services in a timely manner.
- If a service or support required to meet the member's identified needs is not available or accessible by the member in a timely manner, the provider agency must provide or make provision for an alternative service or support to meet the member's identified needs until the requested service becomes available.
- Reapply for approval as an AMHH provider agency every 3 years from the date of initial approval as an AMHH provider agency, as determined by the DMHA.

Application and Attestation Form

The community mental health center (CMHC) must complete and submit a *CMHC Provider Agency Application and Attestation to Provide Adult Mental Health Habilitation Services* (see [Figure 19](#)) to the DMHA.

Figure 19 – CMHC Provider Application and Attestation to Provide AMHH Services

<p style="text-align: center;">CMHC Provider Application and Attestation to Provide Adult Mental Health Habilitation Services</p> <p>I, _____, CEO of _____ CMHC, attest to the following:</p> <p>_____ CMHC is:</p> <ul style="list-style-type: none"> • A DMHA-certified community mental health center (CMHC) in good standing • Accredited by a national accreditation entity approved by the Division of Mental Health and Addiction (DMHA) • An enrolled Medicaid provider • Willing and able to provide AMHH services as described in the CMS approved 1915(i) State Plan Amendment (SPA) (TN12-003), AMHH Rule (405 IAC 5-21.6), and the AMHH module to meet the identified habilitation needs of each eligible recipient, including: <ul style="list-style-type: none"> – Maintaining documentation in accordance with IHCP requirements – Employing staff that are eligible to provide AMHH services • Committed to ensuring that recipients have access to the services and supports needed to meet his/her individual needs. <p>The signature below attests that _____ CMHC requests to become/maintain a DMHA-approved AMHH service provider in the state of Indiana. The above requirements and referenced documents have been read, are understood, and will be implemented in accordance with the FSSA program standards.</p> <p>_____</p> <p>Date: _____</p> <p>Community Mental Health Center CEO</p>

Appendix E: AMHH Application Status Codes

The following table presents the codes regarding the status of the AMHH application.

Table 13 – AMHH Application Status Codes

Status Code	Description
Discarded	The application was discarded by the provider or was in draft mode for more than 60 days and was discarded by the DMHA State Evaluation Team (SET). Applications discarded for either reason have not been submitted for review by the DMHA State Evaluation Team.
Draft	A draft was saved by the provider. The application has not yet been submitted for review by the DMHA SET.
Submitted	The application was submitted by the provider and is undergoing DMHA SET review.
DMHA Pending	The application was pended by DMHA SET for review and potential updates to be made by the provider (that is, the supporting documentation is inconsistent or insufficient for the DMHA SET to make a program and/or services eligibility determination). If not resubmitted within 7 calendar days, the application will be subject to denial based on the original submission.
DMHA Approved	The applicant has been approved for AMHH eligibility by the DMHA SET and all requested services were approved. The application will be forwarded to DXC for service package assignment.
DMHA Approved with Partial Services	The applicant has been approved for AMHH eligibility by the DMHA SET, but one or more of the requested services were not approved. The application and approved requested services will be forwarded to DXC for service package assignment.
DMHA Denied	The application has been denied by the DMHA SET. Therefore, the individual is not eligible for AMHH.
HP Data Sent	The applicant was approved by the DMHA SET and the information has been sent to DXC for AMHH service package assignment.
HP Error	An error occurs if the information sent from DARMHA does not match what DXC has in its system for that member identification (Member ID) (last name, DOB, gender, and so on), or if the format of the file was incorrect.
HP Processed	An AMHH service package assignment has been generated by DXC. AMHH start and end dates and assigned units are viewable in the Provider Healthcare Portal.

Appendix F: AMHH Application Report

The Data Assessment Registry Mental Health and Addiction (DARMHA) system can generate a report indicating the status of all submitted Adult Mental Health Habilitation (AMHH) applications. To create a report:

1. Navigate to the main AMHH application search page by choosing AMHH from the main DARMHA menu. At the AMHH application search page, an empty box labeled Application Status has a drop-down menu showing all the available AMHH application status codes.
2. Select a status code to conduct a query of only the AMHH applications that have been assigned that particular status code. If no status code is chosen, all applications created will be listed.
3. Choose **Print Search Result** to generate a report that can be viewed onscreen.
4. To print the report, select the printer icon at the top of the page.
5. To export the report, select the desired file format from the drop-down menu at the top of the screen and select **Export**. Choose **Open** or **Save** from the dialog box.

To exit the report, choose **Close Report** to return to the AMHH main screen.

DARMHA also has the capability to generate a report that is useful in tracking the AMHH package end dates to identify members approaching the submission period to ensure timely submittal of renewal applications and a report that identifies applications that have ended with no AMHH renewal application submitted. The following steps indicate how to generate these reports:

1. Navigate to the main DARMHA screen.
2. Select **Reports** from the menu.
 - a. To identify AMHH applications that have expired and with no new application being submitted, select AMHH Expired Application No Renewal.
 - b. To identify current AMHH applications and their expiration dates, select AMHH Expiring Applications.

Appendix G: HCBS Residential Setting Screening Tool

The following figures show the pages of the current HCBS RSST (as of July 1, 2019).

Figure 20 – HCBS Residential Setting Screening Tool (First Page) – as of July 1, 2019

HCBS Residential Setting Screening Tool
Effective July 1, 2019

Members who receive services through the AMHH and/or BPHC program are required to live and receive HCBS services in settings that meet federal Medicaid guidelines for home and community-based services (HCBS). This tool is required to be completed (1) with **every member** applying for AMHH and/or BPHC during the development process for **every application** (initial, renewal, and modification), **AND/OR** (2) within 15 calendar days of **any** change in the member's living situation. A completed copy of this screening, with the member's and case manager's signatures in the appropriate section, must be kept with the member's clinical record. In addition, the "Current Living Situation" section on the DARMHA application should reflect the setting identified below.

Member Name: _____ Date of Screening: _____

Member's address: _____

DARMHA ID #: _____ Internal ID #: _____ Benefit: AMHH/BPHC (circle one or both)

Please check the box that best described the member's living situation:

☐ **Identification for Homelessness**
Homeless is defined as: (1) lacking a fixed, regular, and adequate nighttime residence, and/or (2) the primary nighttime residence is: (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodation of 3 or less months, or (b) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street, tent community?).

☐ **Identification for "Private/Independent Home" Setting**
An individual's private home (owned or leased), or a relative's home where the individual resides (owned or leased).

☐ **Identification of a CMHC Provider Owned, Controlled, or Operated (POCO) Residential Setting**
A provider CMHC owned, controlled, or operated (POCO) residential setting is a specific physical place that is owned, co-owned, and/or operated by a CMHC provider of HCBS.

☐ **Identification and Attestation for Non-POCO Residential Setting**
These are most often residential settings that provide some level of daily living support services, such as (*this list is not all-inclusive*):

- Residential Care Facilities County homes
- Residential Care Assistance Program (RCAP) facilities
- Room and Board Assistance (RBA) facilities
- Cluster homes/cluster apartments owned by non-profit agencies

☐ **Identification and Attestation for Non-CMHC POCO Residential Setting**
A provider of HCBS other than a CMHC may operate or be delivering services at that setting. The Indiana FSSA agencies Division of Aging (DA) and Division of Disability and Rehabilitative Services (DDRS) administer four other Medicaid HCBS programs, known as 1915(c) Home and Community-Based Waivers:

- Traumatic Brain Injury (TBI; administered by DA)
- Aged and Disabled (A&D; administered by DA)
- Community Integration and Habilitation (CIH; administered by DDRS)
- Family Supports (FS; administered by DDRS)

Member Signature

Member name (printed)

Date

Case Manager Signature

Case Manager name (printed)

Date

Individuals that reside in a private/independent home, please skip the questions below

Figure 21 – HCBS Residential Setting Screening Tool (Second Page) –
as of July 1, 2018

RSST Ongoing Monitoring Plan																																					
Member Name: _____	Date of Screening: _____																																				
Member's address: _____																																					
DARMHA ID #: _____	Internal ID #: _____																																				
Benefit: AMHH/BPHC (circle one or both)																																					
<p>For ONLY those members that reside in a POCO or non-POCO residential setting, please answer the following questions. If any responses to the following questions are "No," please email this RSST (2nd page) to bphc.services@fssa.in.gov.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td style="padding: 2px;">1. The setting is integrated in and supports residents full access of to the greater community</td><td style="width: 10%;"></td></tr> <tr><td style="padding: 2px;">2. The setting is selected by the individual from among setting options</td><td></td></tr> <tr><td style="padding: 2px;">3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint</td><td></td></tr> <tr><td style="padding: 2px;">4. Enhances individual initiative, autonomy, and independence in making life choices</td><td></td></tr> <tr><td style="padding: 2px;">5. Individuals have a choice regarding services and supports, and who provides them</td><td></td></tr> <tr><td style="padding: 2px;">6. A lease or residency agreement is in place for each HCBS participant and includes protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law</td><td></td></tr> <tr><td style="padding: 2px;">7. Each individual has privacy in their sleeping or living unit</td><td></td></tr> <tr><td style="padding: 2px;">8. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time</td><td></td></tr> <tr><td style="padding: 2px;">9. Individuals are able to have visitors of their choosing at any time</td><td></td></tr> <tr><td style="padding: 2px;">10. The setting is physically accessible to the individual</td><td></td></tr> </tbody> </table> <p>By our signatures, we attest that the member's current living situation is selected correctly and the member answered the exploratory questions (when appropriate).</p> <table style="width: 100%; margin-top: 10px;"> <tr> <td style="width: 30%; border-bottom: 1px solid black;"></td> <td style="width: 10%; border-bottom: 1px solid black;"></td> <td style="width: 30%; border-bottom: 1px solid black;"></td> <td style="width: 10%; border-bottom: 1px solid black;"></td> </tr> <tr> <td>Member Signature</td> <td>Date</td> <td>Case Manager Signature</td> <td>Date</td> </tr> <tr> <td colspan="2" style="border-bottom: 1px solid black; margin-top: 10px;"></td> <td colspan="2" style="border-bottom: 1px solid black; margin-top: 10px;"></td> </tr> <tr> <td colspan="2">Member name (printed)</td> <td colspan="2">Case Manager name (printed)</td> </tr> </table>		1. The setting is integrated in and supports residents full access of to the greater community		2. The setting is selected by the individual from among setting options		3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint		4. Enhances individual initiative, autonomy, and independence in making life choices		5. Individuals have a choice regarding services and supports, and who provides them		6. A lease or residency agreement is in place for each HCBS participant and includes protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law		7. Each individual has privacy in their sleeping or living unit		8. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time		9. Individuals are able to have visitors of their choosing at any time		10. The setting is physically accessible to the individual						Member Signature	Date	Case Manager Signature	Date					Member name (printed)		Case Manager name (printed)	
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Member Signature	Date	Case Manager Signature	Date																																		
Member name (printed)		Case Manager name (printed)																																			

Appendix H: AMHH Service Codes and Rates Table

Table 14 shows the Adult Mental Health Habilitation (AMHH) service codes and reimbursement rates as of July 1, 2018.

Table 14 – AMHH Service Codes and Rates

AMHH Service	HCPCS Code	Modifiers	Unit/Rate
Adult Day Services	S5101	UB	\$28.80 per half-day unit
Home and Community-Based Habilitation and Support with Member (Individual Setting)	H2014	UB	\$26.14 per 15-minute unit
Home and Community-Based Habilitation and Support with Family and Member (Individual Setting)	H2014	UB HR	\$26.14 per 15-minute unit
Home and Community-Based Habilitation and Support with Family without the Member Present (Individual Setting)	H2014	UB HS	\$26.14 per-15 minute unit
Home and Community-Based Habilitation and Support with Member (Group Setting)	H2014	UB U1	\$4.71 per-15 minute unit
Home and Community-Based Habilitation and Support with Family and Member (Group Setting)	H2014	UB U1 HR	\$4.71 per-15 minute unit
Home and Community-Based Habilitation and Support Services with Family without the Member present (Group Setting)	H2014	UB U1 HS	\$4.71 per-15 minute unit
Respite Care (Hourly)	S5150	UB	\$3.50 per 15-minute unit
Respite Care (Daily)	S5151	UB	\$100.00 per 1-day unit
Therapy and Behavioral Support Services with Member (Individual Setting)	H0004	UB	\$28.65 per 15-minute unit
Therapy and Behavioral Support Services with Family and Member (Individual Setting)	H0004	UB HR	\$28.65 per 15-minute unit
Therapy and Behavioral Support Services without the Member Present (Individual Setting)	H0004	UB HS	\$28.65 per 15-minute unit
Therapy and Behavioral Support Services with Member (Group Setting)	H0004	UB U1	\$7.16 per 15-minute unit
Therapy and Behavioral Support Services with Family and Member (Group Setting)	H0004	UB U1 HR	\$7.16 per 15-minute unit
Therapy and Behavioral Support Services without the Member Present (Group Setting)	H0004	UB U1 HS	\$7.16 per 15-minute unit
Addiction Counseling with Member (Individual Setting)	H2035	UB	\$58.32 per 1-hour unit
Addiction Counseling with Family and Member (Individual Setting)	H2035	UB HR	\$58.32 per 1-hour unit

AMHH Service	HCPCS Code	Modifiers	Unit/Rate
Addiction Counseling with Family without the Member Present (Individual Setting)	H2035	UB HS	\$58.32 per 1-hour unit
Addiction Counseling with Member (Group Setting)	H2035	UB U1	\$14.58 per 1-hour unit
Addiction Counseling with Family and Member (Group Setting)	H2035	UB U1 HR	\$14.58 per 1-hour unit
Addiction Counseling with Family Without the Member Present (Group Setting)	H2035	UB U1 HS	\$14.58 per 1-hour unit
Peer Support Services	H0038	UB	\$8.55 per 15-minute unit
Supported Community Engagement Services	97537	UB	\$26.14 per 15-minute unit
Care Coordination	T1016	UB	\$14.53 per 15-minute unit
Medication Training and Support with Member (Individual Setting)	H0034	UB	\$18.62 per 15-minute unit
Medication Training and Support with Family and Member (Individual Setting)	H0034	UB HR	\$18.62 per 15-minute unit
Medication Training and Support with Family Without the Member Present (Individual Setting)	H0034	UB HS	\$18.62 per 15-minute unit
Medication Training and Support with Member (Group Setting)	H0034	UB U1	\$3.35 per 15-minute unit
Medication Training and Support with Family and Member (Group Setting)	H0034	UB U1 HR	\$3.35 per 15-minute unit
Medication Training and Support with Family Without the Member Present (Group Setting)	H0034	UB U1 HS	\$3.35 per 15-minute unit